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ABSTRACT

Focusing on the physical well-being and personal environment of the Indian elderly, the conference attracted 3,000 persons from 209 Indian tribes. Its program was organized into: (1) description of existing resources serving elderly Indians; (2) determination of the additional or remedial action required; and (3) identification of methodology for accomplishing remedial action and providing continuous evaluation of services. During the 17 workshop sessions conference participants explored the problems and needs of elderly Indians and made recommendations for action in the areas of health care, mental health, nursing homes and alternatives, housing, and transportation. Among the concerns voiced were the wish to be treated as elders and in the manner that Indian tradition once taught, the desire to remain in Indian communities and cultures, and the need for more Senior Citizens' Centers and nutrition programs that would include native foods. Most of the 21 resolutions adopted called for action by the federal government's Departments of Health, Education and Welfare, Housing and Urban Development, Labor, and Transportation. This final report gives the background of the conference, includes its speeches, agenda and activities, lists the recommendations and resolutions, and cites responses to some of them. Five documents in the appendix present information on such topics as the social and psychological states, physical and mental health, and the environment of the Indian elderly. (DS)

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FINAL REPORT ON THE
Second National Indian Conference On Aging
BILLINGS, MONTANA
AUGUST 15-18, 1978

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THE CONTINUUM OF LIFE: HEALTH CONCERNS OF THE INDIAN ELDERLY

FINAL REPORT ON THE SECOND NATIONAL INDIAN CONFERENCE ON AGING BILLINGS, MONTANA, AUGUST 15-18, 1978

Sponsored by the
NATIONAL INDIAN COUNCIL ON AGING
P.O. Box 2088
Albuquerque, New Mexico 87103

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The summary of conference recommendations and material included in the appendices represents input from conference participants and others and does not necessarily reflect the views or policies of the National Indian Council on Aging or the Department of Health, Education and Welfare.

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FOREWORD

"Each creature moves in cycles with the creation. Some sleep during the cold, others move south. The salmon return from the oceans, the deer seek their pastures—as the ducks and geese fly north to raise their families, we wonder——how are we to move in the cycles of creation?"

Akwesasne Notes — Calendar, 1977

In our return to harmony with the cycles of Creation, we understand that cycles having these powers must affect our lives in many ways—ways of which we are no longer aware. The cycles of Creation vary distinctly across this large Indian land. The corn ripens in Oklahoma months before it is ready in Iroquois country. The "Moon of the Salmon Run" would have significance to the people in the Northwest, but would lack meaning to people living in the Southwest.

Many of our Indian dances are in honor of Mother Earth, some Indian tribes dance in the direction in which the earth turns, saying that this will help the earth to grow. Mother Earth has various cycles, there are times to work and times for rest and quiet. There are times for creating and times when parts of her die so new life can come. We are instrumental in some of her cycles; the things which we receive from the earth must be returned to her so that her life can continue.

The sense of our native history encompasses the significance of an event in the cycles of the Creation. People need to return to the patterns of life which the Creation has set in motion for us. Cycles occur in ourselves, the cycles of our moods, our health, our energies, our ages and our life.

In our efforts to strengthen our spirits and return to the cycles of the Creation, the daily cycle of the Sun provides the most prominent example for us to follow. The Brother Sun rises, bringing light, and sets, bringing darkness. The example is a reminder of the stages of existence and the spiritual growth through which we, as human beings, have come. When we fail to observe the movements, we lose understanding of them and fail to act in harmony with Creation. As we lose respect for Mother Earth and Creation, we impair our ability to insure life for our future.

Robyn J. York
Conference Coordinator

SPECIAL ACKNOWLEDGEMENTS

The National Indian Council on Aging, Inc., extends its appreciation for the cooperation and support of the following agencies and organizations:

The Indian Health Service, U.S. Public Health Service, Dept. of H.E. W.
Emery Johnson, M.D., Assistant Surgeon General, Director, IHS
Mrs. Joe Bales Graber, Director, Bureau of Health Resources. IHS
Billings Area—IHS, James Smith, Area Director and Staff
Albuquerque Area—IHS, Jay Harwood, Area Director and Staff
The Bureau of Indian Affairs, Department of the Interior
Billings Area—BIA, James Cannon, Area Director and staff
Billings Area Indian Health Board and staff
Billings Chamber of Commerce
Billings Convention and Visitors Bureau
Northern Cheyenne Tribal Council and Staff
Allen Rowland, President
Tribal Elders of Montana, Cynthia LaCounte, Director
National Indian Health Board and Staff
American Indian Travel Commission Staff
Affiliated Tribes of the Fort Berthold Reservation of North Dakota
American Indian Nurses Association Staff
White Cloud Center, National Center for American Indian and Alaskan Native Mental Health Research and Development Staff

The Montana Indian Tribes:
Crow
Blackfeet
Flathead

Tribal Councils and Tribal Health Boards:
Fort Belknap
Fort Peck
Rocky Boy's

and the many Indian individuals who gave their time and effort for the benefit of the Indian elderly and in support of the conference program and functions.

Conference Report

Organizational Areas of the National Indian Council on Aging

Groupings of States by Areas

Aberdeen Area—Nebraska, North Dakota, and South Dakota

Albuquerque Area—Colorado and New Mexico (with the exception of the Eastern Navajo Reservation)

Anadarko Area—Kansas and Western Oklahoma

Billings Area—Montana and Wyoming

Central Area—Florida, Mississippi, New York, and North Carolina; New England—Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont

Juneau Area—Alaska

Minneapolis Area—Iowa, Michigan, Minnesota, and Wisconsin

Muskogee Area—Eastern Oklahoma

Navajo Area—All portions of the Navajo Reservation in Arizona, New Mexico, and Utah

Phoenix Area—Arizona (with the exception of the Navajo Reservation), Nevada, and Utah

Portland Area—Idaho, Oregon, and Washington

Sacramento Area—California

INTRODUCTION

The Second National Indian Conference on Aging was sponsored by the National Indian Council on Aging in Billings, Montana, on August 16-18, 1978. "Continuum of Life" was the conference theme, and the focus was on the Physical Well-Being and Personal Environment of the Indian elderly.

The conference attracted 3,000 persons, who represented 209 different Indian tribes, both federally and state recognized, and 40 different states. The Indian elderly and representatives of service providers largely composed the conference body. The participation of numerous Indian leaders of both the local and national levels and representatives of national Indian organizations was particularly encouraging. This event was successful by standards of high attendance, great interest and overall positive public responses.

The Indian elderly came together in the "Big Sky Country" to acquire aging and health program information, to compare assets of their own local aging programs, and to discuss their local health or environmental problems. The feelings of the elderly about themselves and their fellow tribesmen were of concern for total well-being. Many of the elderly Indians also expressed appreciation for the acknowledgement of their plight in "just fighting for survival." The attitudes displayed and observed were of enthusiasm and desire to accomplish remedial actions, not of defeatism.

The concerns and problems that surfaced and were recognized by the National Indian Council on Aging will be developed into action plans for follow-up in the near future.

It is hoped that this Summary Report of the Second National Indian Conference on Aging by the National Indian Council on Aging will reflect the hopes and encouraging faith of the Indian elderly. Within this report, we will list the recommendations, resolutions, responses and activities of the Conference.

BACKGROUND

The first National Indian Conference on Aging was sponsored by the National Tribal Chairmen's Association in June of 1976 in Phoenix, Arizona. It was supported, in part, by a grant, No. 90-A-775, from the Administration on Aging, Office of Human Development, Department of Health, Education and Welfare, and received substantial in-kind contributions from the Bureau of Indian Affairs and the Arizona Department of Economic Security. That conference ended five years of frustration in the national Indian community, caused by vain attempts of Indian people to revive the vital issues raised in the special Indian Concerns Session at the 1971 White House Conference on Aging.

Through the initiative of the Phoenix Area Indian Tribes (from Arizona, Nevada, and Utah) and the Navajo Nation, these issues were kept alive. Full credit goes to Wendell Chino, President of the Mescalero Apache Tribe of New Mexico, then serving as President of the National Tribal Chairmen's Association, for his strong support of the effort to convene a National Indian Conference on Aging. With the approval of the Board of Directors of the National Tribal Chairmen's Association, the Phoenix Area Indian Tribes and the Navajo Nation were delegated authority to coordinate the planning effort and to take every action necessary to bring the conference about. The most immediate result of the Conference was the formation of a National Indian Task Force on Aging, which was given the mandate to follow up on all recommendations made at the Conference. This the Task Force set about to do by incorporating as the National Indian Council on Aging and submitting an application for federal assistance to fund a national Task Force operation to the Administration on Aging, which was granted as of September 30, 1976.

Based on responses to a pre-Conference questionnaire mailed to Indian tribes, organizations, and individuals nationwide, the greatest areas of concern were found to be those relating to Income, Personal Environment, Legal Problems, Physical Well-Being, and Legislation. Accordingly, these were the five subject areas into which workshops at the Conference were divided.

The workshops on **Physical Well-Being** and **Personal Environment** drew the greatest number of participants and, had the Conference lasted for 30 days instead of 3, participants would not have exhausted the number of concerns they wished to present.

According to visual observation, the first National Indian Conference on Aging was attended by over 1500 Indian people representing 171 distinct Indian tribes and Alaskan Native communities. Of those participants who completed a Conference Evaluation Questionnaire, 93.9% indicated that they would like to attend future national Indian conferences on Aging. In recognition of the heavy emphasis placed by Conference participants on health and related concerns, the National Indian Council on Aging intensified its liaison and coordination efforts with the Indian Health Service, U.S. Public Health Service. The results were gratifying. Dr. Emery Johnson, Director of the Indian Health Service, gave assurance of continued close cooperation with the National Indian Council on Aging. At the same time, previously established cooperative relations with the Aging Committee of the Indian Health Service, consisting of ten regional representatives under the chairmanship

of Mrs. Joe B. Graber, Director of the IHS Office of Health Resources, were continued.

Also, in 1976, a significant event occurred which emphasized the desire of the National Indian Council on Aging to concentrate a major portion of its efforts on health-related issues. This was the passage of the Indian Health Care Improvement Act, Public Law 94-437, which was designed "to implement the Federal responsibility for the care and education of the Indian people by improving the services and facilities of Federal Indian health programs and encouraging maximum participation on Indians in such programs, and for other purposes, etc.".

The health needs of the American Indian* elderly were not only articulated by the participants in the 1976 National Indian Conference on Aging, but are underscored in **A Health Profile of the Aging and Aged Service Population with a Report on Related Activities** prepared by the Indian Health Service Committee on Aging for inclusion in the final report on the first National Indian Conference on Aging.

In 1977, the newly formed National Indian Council on Aging, in promoting continuity for their national conferences, decided to focus on the two largest areas of concern shown by the conference audience of 1976. In an application for federal assistance to the Administration on Aging, it was proposed to convene the Second National Indian Conference on Aging, with emphasis on health and health-related issues, in 1978. The conference was to be held in cooperation with the Indian Health Service and with national Indian organizations and institutions with a health focus.

The proposal submitted to the Administration on Aging was funded on September 30, 1977, for $93,342 for one project year to end on September 30, 1978. The purpose of the grant award was to plan, coordinate, implement, and later report on the Second National Indian Conference on Aging. These were the specific purposes: to focus national attention on the unmet health-related needs of the American Indian/Alaskan Native elderly, to generate greater sensitivity to health related needs of Indian elders among governing bodies of the Indian community and staff of agencies capable of remedial action, and to stimulate research concerning health-related conditions of the Indian elderly and subsequent action to improve remedial services.

In-kind contributions were made by the Indian Health Service and the Bureau of Indian Affairs. The most substantial contributors of support were the two primary agencies involved, the Indian Health Service and Bureau of Indian Affairs. Offers of support were received early from the Northern Cheyenne Tribe, Billings Area Indian Health Board, Billings Chamber of Commerce, Tribal Elders of Montana, Eastern Montana College, the Coordinator of Indian Affairs and the Department of Aging Services Bureau, both of the State of Montana. Since it would have been most difficult to travel the entire State of Montana to secure support, whether monetary or in manpower, this was an ideal network of support.

* The term "American Indian" includes reference to Alaskan Natives.

PROJECT OBJECTIVES

The immediate goal of the project was a coordinated approach to the provision of effective and adequate health-related services needed by the American Indian elderly by combining input from the Indian community with that of service providers and representatives of the governing bodies of the national Indian community. The long-range goal is an improved standard of health for the Indian elderly according to their own culturally-based needs.

The main objectives of the conference project were:

1. Provide a forum for the Indian community nationwide to express its concerns and special needs in the area of health services and environmental concerns to the Indian elderly.

   Specifically, input will be solicited from participants on:

   a. Status and effectiveness of existing services.
   b. Identification of unmet needs.
   c. Recommendations for modification, improvement, methodology, future planning, implementation, follow-up, and continuity of Indian input.
   d. Establishment and maintenance of mutually acceptable cooperative relations between the Indian elderly community and
      (1) The Indian Health Service (DHEW)
      (2) Other federal agencies capable of providing complementary services
      (3) State and local agencies providing health and related services to the Indian elderly.
   e. Accomplishment of maximum utilization of all available resources within the context of Indian culture and heritage.

2. Provide accurate, and current information to the Indian community on resources available to serve the elderly, many of which may not have been utilized, and on the status of ongoing legislative efforts in the field of Aging.
3. Determine methodology and plan for implementation of positive and continuous action

leading to improved comprehensive services for the Indian elderly.

4. Promote sensitivity to needs, problems and cultural differences of elderly Indians among non-Indian agency representatives.

CHRONOLOGY

During the November quarterly meeting of the National Indian Council on Aging in 1977, Madeline Colliflower, Billings Area Board Member, invited NICOA to convene its Second National Indian Conference on Aging in Billings, Montana. The Council established the tentative dates of August 16-18, 1978, and accepted the recommendation of the conference site.

In early February of 1978, the conference staff met with Ms. Colliflower in Billings for an assessment of the conference location with regard to logistics, conference programming, and local support. While in Montana, visits were made to nearby Indian tribes to generate interest and support. The assessment was that Billings could accommodate the conference adequately.

At the NICOA quarterly Council meeting in Tucson, Arizona, in the same month, Ms. Colliflower presented letters in support of the conference from the following organizations and agencies:

Billings Chamber of Commerce
Billings Area Indian Health Board
Northern Cheyenne Tribe
Eastern Montana College
Billings Indian Center
Tri-State Tribes, Inc.
Area Director—Bureau of Indian Affairs
Area Director—Indian Health Service

Present as a guest speaker was Morris K. Udall, (Arizona), Member of the U.S. House of Representatives and Chairman, House Committee on Interior and Insular Affairs, 95th Congress, who expressed his support for the conference and its objectives.

At this time, the NICOA General Council finalized approval of the site and dates of the conference and designated the Montana Convention Center of the Holiday Inn-West as the central conference location.

In March, the National Conference Planning Committee held its first meeting in Billings, Montana, to begin the initial planning. All Indian Reservations in Montana, the State Coordinator of Indian Affairs of Montana, and the Montana State Aging Services Bureau, the Mayor of Billings, Billings Convention and Visitors Bureau, the Billings Area Indian Health Board, and the director of the Tribal Elders of Montana were invited to attend the meeting. It was felt that it would be most advantageous to involve the Montana delegation in establishing the specific objectives of the conference.

The National Indian Health Board (NIHB) invited NICOA to make a presentation on the upcoming conference at its quarterly Board meeting in Portland, Oregon, in April. Mrs. Pearl Warren, Portland Area Board Member, and Ms. Robyn York, NICOA staff, attended the meeting. The NIHB members and staff were supportive of the conference objectives and the health focus. James Meredith, Chairman, Council of Area Directors and Area Director, USET* Area, stated they would continue to support the conference and its objectives. A National Indian Health Board Resolution, No. 4-78-A, endorsing the conference, was passed unanimously at this meeting on April 24-28, 1978.

Resolution 4-78-A

Support For the Second National Indian Conference on Aging

WHEREAS, the unmet health related needs of the American Indian and Alaska Native elderly have been and continue to be a concern of the National Indian Health Board; and

WHEREAS, the National Indian Health Board has previously gone on record by passing resolution 2-78-C at its February 1978 meeting in Albuquerque, New Mexico as urging a united effort to raise health-related services for the Indian/Alaska Native elderly from the present low priority; and

WHEREAS, the Second National Indian Conference on Aging to be held in Billings, Montana on August 16-18, 1978 will provide a forum for a coordinated approach to the provision of effective and adequate health-related services needed by the American Indian and Alaska Native elderly;

NOW, THEREFORE BE IT RESOLVED, that the National Indian Health Board supports the efforts of the National Indian Council on Aging, Inc. in sponsoring the forthcoming Second National Indian Conference on Aging.

Certification

It is hereby certified that at the regular meeting of the National Indian Health Board held in Portland,

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* USET—United Southeastern Tribes. Ed.

Oregon, April 24-28, 1978, the foregoing resolution was presented and approved by a majority vote of those Board of Directors present.

(s) Howard E. Tommie, Chairman

***

Supporting the conference and the tentatively planned Congressional hearing was Mr. Gary A. Refsland, Center of Gerontology, Montana State University, Bozeman, Montana. He shared a copy of his May 4, 1978, letter to Senator John Melcher, Montana, a member of the Senate Special Committee on Aging, requesting that the committee conduct a hearing at the conference on the concerns of the American elderly. Mr. Refsland stated, "We support and endorse the efforts of the National Indian Council on Aging in this regard and join with them in extending an invitation to you and Senator Church to attend the conference and conduct the congressional hearing".*

The final meeting of the National Conference Planning Committee took place in Albuquerque, New Mexico, on June 21-22, 1978. This meeting was scheduled in order to finalize all aspects of the conference. From this time on until August, the momentum of enthusiasm and interest for the conference increased.

Sophie D. Thompson, Conference Chairperson, and Board Member (Navajo Area) of the National Indian Council on Aging

PROJECT STAFF

The overall professional project staff consisted of the volunteer Conference Chairperson, Sophie D. Thompson, Area Social Worker of the Indian Health Service, Navajo Area, the Executive Director, Juana P. Lyon, Assistant Director, James Bluestone and Executive Secretary, Robyn York. The conference project's Executive Secretary worked in the capacity of an Administrative Assistant. Only the Executive Secretary was employed under Administration on Aging Grant 90-A-1253.

It was anticipated that staff in support of a number of activities at the conference itself would be made available by cooperating agencies. Such staff positions included but were not limited to registration and telephone message clerks, workshop recorders, etc. The National Indian Council on Aging appointed local committees in support of conference activities.

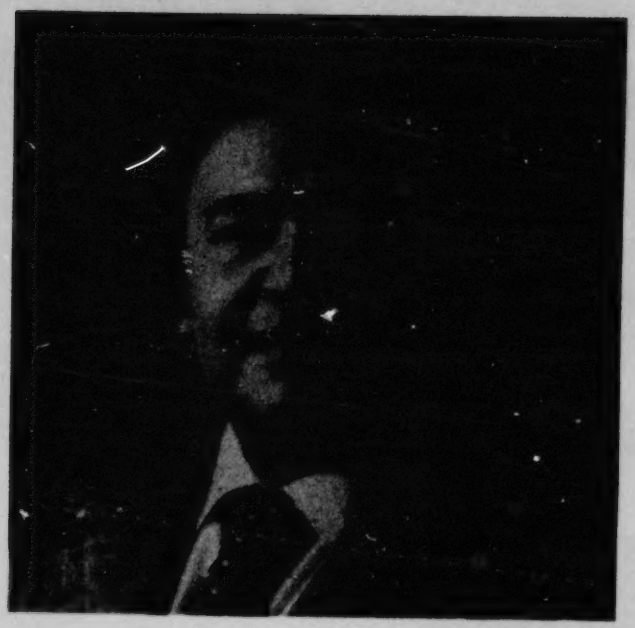
The project volunteer efforts were spearheaded by Cynthia LaCounte, Director, Tribal Elders of Montana, Doris Limberhand, Program Manager, Billings Area Indian Health Board, and Pearl Youngbear of the Northern Cheyenne Tribe. These organizations provided the volunteer staffs of assistants, secretaries, security workers, cooks and media workers.

In order to ensure leadership and participation of persons with expertise in health or health-related fields, moderators, panelists, and speakers were enlisted as consultants for the workshops or the plenary sessions. Where required, NICOA paid for travel and per diem expenses of these individuals.

Staff of other projects of the National Indian Council on Aging provided extensive support to the conference project. They were: Larry Curley, Liaison Specialist; Ernesto Lujan, Staff Accountant; Mary Poppy, Director, Operations Research; Anne Blakeley, Liaison Assistant; Callie Hinman, Administrative Secretary; Peggy Ross, Secretary; and Kathy Nahwooksy, CETA worker.

All staff persons, who were already carrying heavy workloads, contributed much to the operating functions at the conference. This was greatly appreciated as the anticipated attendance increased from 2,000 to 3,000 participants.

* Due to irreconcilable congressional scheduling conflicts, it was not possible to hold the hearing. Ed.



George Effman (Klamath-Karok), Chairman, National Indian Council on Aging.

Madeline Colliflower, NICOA Board Member (Billings Area), member of Conference Planning Committee and official hostess on behalf of Montana Tribes.

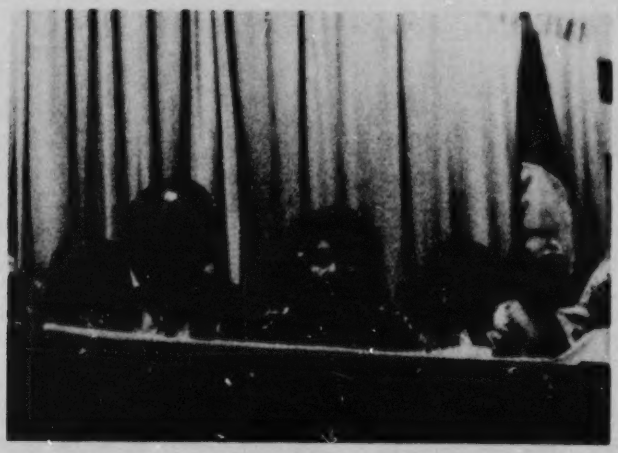
Chauncina White Horse, NICOA Board Member (Minneapolis Area), and member of Conference Planning Committee.

Syble Askenette, NICOA Board Member (Phoenix Area) and member of Conference Planning Committee.

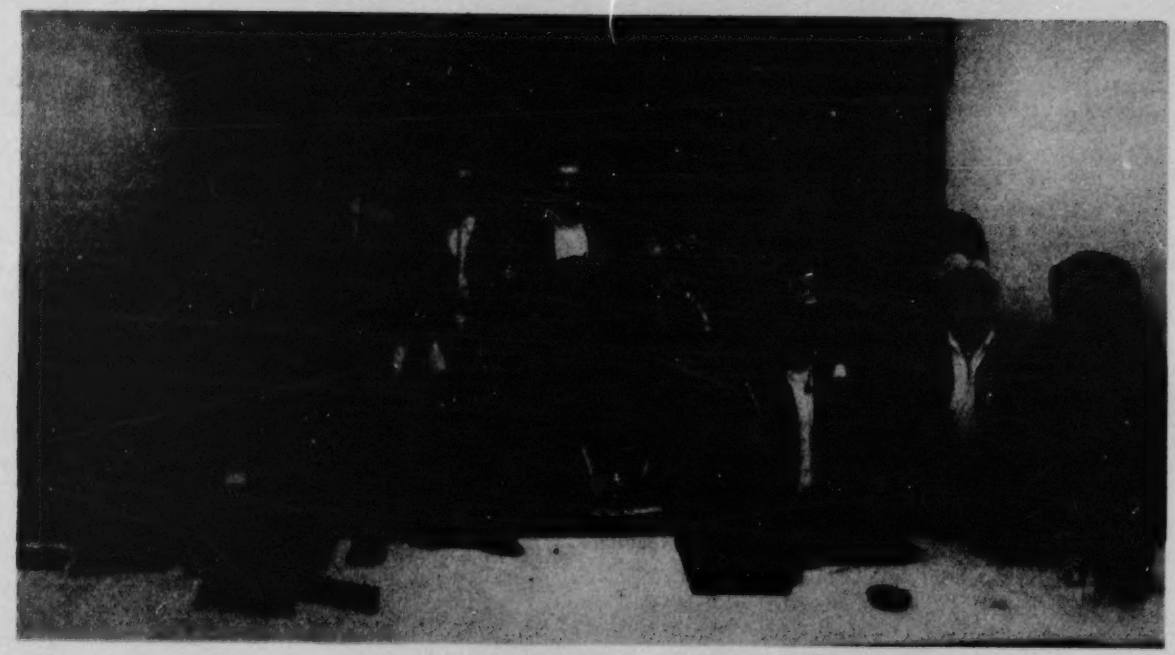
Cecelia Blanchard, NICOA Board Member (Anadarko Area) and member of Conference Planning Committee.

Pearl Warren, NICOA Member (Portland Area) and member of Conference Planning Committee.

Cecelia Montgomery, NICOA Member (Aberdeen Area) and member of Conference Planning Committee.



l to r: Wendell Chino, NICOA Honorary Chairman, Madeline Colliflower, Board member (Billings Area), Mrs. Lillard, Sherman Lillard, Board Member (Central Area).



Members of the National Indian Council on Aging at the time of the Conference and their tribal affiliation: (back row—left to right): Sherman Lillard, Secretary (Eastern Cherokee), John Carlile, Vice-Chairman (Cherokee of Oklahoma), Joseph F. Abeyta, Sr. (Santa Clara Pueblo), Jess J. Stevens (San Carlos Apache), Bob Pinezaddleby (Kiowa), Lawrence Birdsbill (Hidatsa-Mandan), Walter Moffett, Treasurer (Nez Perce); (third row) Anna John (Oneida), Robert Holmes (Ottawa), Ramona Azure (Assiniboine), Syble Askenette (Hoopa), Carrie Preston (Alternate—Choctaw), Chauncina White Horse (Oglala Sioux), Alvina Mofsie (Winnebago), Cecelia Montgomery (Oglala Sioux), Josephine Goodwin (Chippewa); (second row) Pear Warren (Makah), Bette Scott (Winnebago), Eunice Baumann-Nelson (Penobscot), Juanita Espinosa (Chumash); (front row) Winifred Tiger (Eastern Cherokee), Madeline Colliflower (Gros Ventre of Montana), George P. LaVatta (ShoshoneBannock), Cecelia Blanchard (Kickapoo of Oklahoma), Adeline Wanatee (Sac & Fox of the Mississippi), Arlene Naquayouma (Papago-Pima), Sophie D. Thompson (Navajo), Violet Booth (Tsimpshean), Louva Dahozy (Navajo). Not shown are George Effman, Chairman (Klamath), Alexander Ami (Hopi), Claude Devers (Pauma), Lorena Dixon (Luiseno Pauma), Phoebe Cloud (Southern Ute), Victor Haldane (Haida), Allan Jemison (Seneca), Mary Wamego (Prairie Band Potowatomi), Narcissus Gayton (Mescalero Apache), Tonya Parker (Choctaw), Leonard Tomaskin (Yakima), Cecil Williams (Papago), and Wendell Chino, Honorary Chairman (Mescalero Apache).

PROJECT SUPPORT FROM OTHER AGENCIES

Outstanding support of conference planning and functions was provided by the Central Offices of the Indian Health Service and the Bureau of Indian Affairs in Rockville, Maryland and Washington, D.C. respectively. The lead at the Area levels of the Indian Health Service was shared by the Albuquerque, Billings, and Navajo Areas.

The Bureau of Indian Affairs provided office space and access to the government FTS Telephone System for the conference project in Albuquerque. This was an integral part of the operating capabilities of the project, since the conference site was a great distance away. The Bureau of Indian Affairs in Billings provided clerical workers and Xerox services during the conference.

Dr. Emery Johnson, Director, Indian Health Service, assisted in the dissemination of conference information by ensuring participation of members of the IHS Committee on Aging, by designating Mrs. Joe B. Graber, Chairperson, IHS Committee on Aging, as contact person for the conference planning and efforts. Mrs. Graber was also the Project Officer for the (5) IHS Contract Papers reproduced in Appendices. The Indian Health Service in Billings contributed outstanding support through James Smith, Area Director, who made IHS staff available for participation on the National Conference Planning Committee (NCPC) during the planning stages and at the time of the conference. Mr. Smith's assistance enabled NICOA to achieve a good working environment for this large conference some 1,000 miles from its national offices.

The Indian Health Service in Albuquerque also provided continuous staff support and cooperation through Jay Harwood, Area Director. Mr. Harwood, well-known for his ability as Master of Ceremonies, was invited to participate for the conference banquet and accepted wholeheartedly. The National Center for American Indian and Alaskan Native Mental Health Research and Development (Whitecloud Center) provided the travel and accommodations for the participation of Ms. Audra Pambrun on the National Conference Planning Committee, as well as the assisting Whitecloud Center staff, to implement the mental health survey and compile the results.

Other Indian planners and organizations supporting the conference efforts were the National Indian Health Board, American Indian Travel Commission, American Indian and Alaskan Native Nurses Association, Chemawa Indian School (BIA), Tribal Elders of Montana, Fort Peck Reservation, Northern Cheyenne Tribe, Four State Indian Health Board, National American Indian Safety Council and the Association of American Indian Physicians. The Administration on Aging, Region VIII, also provided staff support.

METHODOLOGY

Brief Outline of the Methodology for the Second National Indian Conference on Aging

1. Input was based upon recommendations from the 1976 conference and related issues from the Indian communities, i.e., national organizations, groups and staffs.
2. The Planning Committee developed the agenda and activities from the above-mentioned input. The tentatively scheduled general assemblies and workshops were advertised for further general input.
3. Based upon the general approval of the national Indian community, NICOA Council and Board, and service providers, the conference agenda was finalized.
4. Out of the conference discussions, workshop recommendations and resolutions were developed and endorsed by the conference body of the Second National Indian Conference on Aging on August 18, 1978.
5. The recommended remedial actions and resolutions are documented in this Summary Report of the Second National Indian Conference on Aging.

The methodology was based upon the conference objectives while further emphasis and programming were developed from interaction of representatives of the Indian elderly community with representatives of tribal governments and service provider agencies. The planning and the conference agenda reflected input from the Indian communities, the National Indian Council on Aging, Indian Health Service representatives and other Indian groups with interests in health-related issues. The agenda included keynote speakers who demonstrated an interest in the total well-being of the Indian elderly, and workshops with moderators and panelists sharing their knowledge and expertise in the respective subject areas. (Refer to Page 61 for Conference agenda.)

During the entire planning process, the National Indian Council on Aging, through its previously established channels and organizational linkages, consulted with local, statewide and national Indian organizations on the conference focus. They assisted in identifying and recommending specific issues to be addressed at the conference.

The National Indian Council on Aging named eight

members as consumer representatives to the National Planning Committee. The Indian Health Service, the National Tribal Chairmen's Association, the National Congress of American Indians, and other national Indian organizations with a related focus were invited to nominate participants to the Planning Committee. The Planning Committee held two meetings, the first in Billings, Montana, on March 28-30, 1978, and the second in Albuquerque, New Mexico, on June 21-22, 1978

National Conference Planning Committee

The National Indian Council on Aging, the Indian Health Service, and other supportive organizations named thirty members to the planning committee. Representing the National Indian Council on Aging:

George Effman (Klamath-Karok), Chairman,
Sacramento, California
Sophie D. Thompson (Navajo), Conference
Chairperson, Window Rock, Arizona
Madeline Colliflower (Gros Ventre), NICOA Board
Member Host, Dodson, Montana

NICOA Committee on Physical Well-Being:
Pearl Warren (Makah), Kingston, Washington
Bette Scott (Winnebago), Winnebago, Nebraska
Cecelia Blanchard (Kickapoo), Shawnee, Oklahoma

NICOA Committee on Personal Environment:
Chauncina White Horse (Oglala Sioux),
Bensenville, Illinois
Syble Askenette (Hoopa), Carson City, Nevada
Cecelia Montgomery (Oglala Sioux), Rapid City,
South Dakota

Other contributing Indian representatives and organizations:

John Belindo (Navajo-Kiowa), Executive Director
National Indian Health Board
Denver, Colorado

Loretta Bad Heart Bull (Standing Rock Sioux),
Aging Specialist
DHEW, AoA, Region VIII
Denver, Colorado

Ed Lonefight (Hidatsa-Mandan-Sioux),
Superintendent
Chemawa Indian School
Bureau of Indian Affairs
Salem, Oregon

Audra Pambrun (Blackfeet), Program Analyst
Whitecloud Center
Portland, Oregon

Earl Old Person (Blackfeet), Area Representative
National Tribal Chairmen's Association
Browning, Montana

Steven Pratt (Osage), Assistant Director
American Indian Nurses Association
Norman, Oklahoma

Cynthia LaCounte (Turtle Mountain Chippewa),
Director
Tribal Elders of Montana
Harlem, Montana

Allen Rowland (Northern Cheyenne), President
Northern Cheyenne Tribe, Inc.
Lame Deer, Montana

Doris Limberhand (Northern Cheyenne),
Program Manager
Billings Area Indian Health Board
Billings, Montana

Indian Health Service—Members of the Committee on Aging:

Joe B. Graber, Chairperson
Office of Health Resources
IHS Headquarters
Rockville, Maryland

Vesta Starkey, Chief, Social Services
Albuquerque Area
Albuquerque, New Mexico

Al J. Folz, Chief, Social Services
Portland Area
Portland, Oregon

Frances W. Dixon, Area Social Services/Mental
Health Officer
Billings Area
Billings, Montana

Lucien Poussard, Chief, Social Services
Anchorage Area
Anchorage, Alaska

John W. Bjork, Chief, Mental Health/
Social Services
Oklahoma Area
Oklahoma City, Oklahoma

Richard L. Varner, Chief, Area Mental Health/
Social Services
Aberdeen Area
Aberdeen, South Dakota

Ella Rumley (Papago), EEO Officer
Phoenix Area
Tucson, Arizona

Pat Roseleigh, Chief, Nutrition and Dietetics
IHS Headquarters
Rockville, Maryland

Rosemary Woods (Osage), Chief, Nursing Branch
IHS Headquarters
Rockville, Maryland

Planning Committee Duties

The duties of the National Conference Planning Committee were:

Select agenda items based on input recorded in the 1976 Conference Summary Report in the health-related subject areas and provided to delegates prior to the planning meetings, and on their own suggestions;

Identify prospective speakers, moderators and panelists for workshops and general assemblies;

Suggest and assist with coordination of conference activities;

Assist with nationwide dissemination of preconference information;

Identify individual volunteer conference workers and participate in on-site conference committees;

Plan conference follow-up and continuity of nationwide coordination;

Work in close coordination with project staff and the sponsoring organization;

Assist with dissemination of information on available sponsored participant slots and selection of these participants.

CONFERENCE NOTIFICATION

Special invitations were extended to congressional leaders and staff whose roles were pertinent to the concerns of the Indian elderly.

The National Indian Council on Aging and the Indian Health Service Committee on Aging provided continuous liaison with cooperating agencies and assisted the project staff to disseminate information on the conference and activities.

In the notification efforts, the project staff utilized the press media including the American Indian press, the NICOA Newsletter, the general press and the local press. Excerpts from the press release included in the NICOA Newsletter follow:

MONTANA SITE FOR THE SECOND NATIONAL INDIAN CONFERENCE ON AGING

Billings, Montana, was selected as the site of the Second National Indian Conference on Aging. The conference site will be the Montana Convention Center, Holiday-Inn West, on August 16-18, 1978. The conference will attract approximately 2,000 to 3,000 participants from all over the United States.

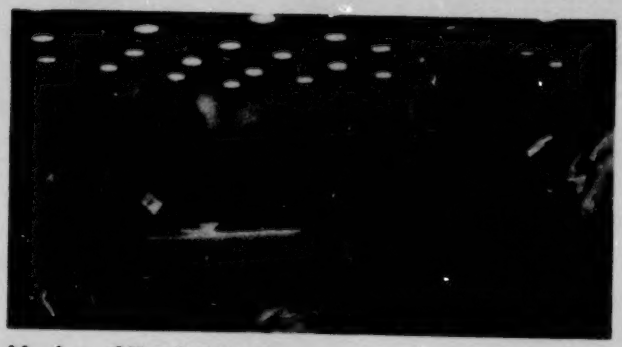
Our objective for the conference is a coordinated approach to the provision of effective and adequate health-related services needed by the American Indian elderly by combining input from the Indian community with that of service providers and representatives of the governing bodies of the national Indian community. The long-range goal is an improved standard of health for Indian elderly according to their own cultural and health needs.

Sophie D. Thompson (Navajo), Conference Chairperson, stated, "Some of the workshops planned are Housing of the Indian Elderly, Alcoholism and the Indian Elderly, Spiritual Aspects of Aging, the Physical Well-Being and Mental Health of the Indian Elderly, Community Services for the Indian Elderly, Alternatives to Institutional Care for the Indian Aged. This forum is being provided for the Indian community to express its concerns, special needs and possible solutions." Ms. Thompson added, "We would like to receive input from the conference participants on the status and effectiveness of existing services. One other concern would be the establishment and maintenance of mutually acceptable cooperative relations between the Indian elderly community and service provider agencies."

Keynote speakers invited to participate in the conference include: Mr. Wendell Chino, Honorary Chairman of the National Indian Council on Aging and Past President of the National Tribal Chairmen's Assn., President of the Mescalero Apache Tribe of New Mexico; Mr. Howard Tommie, Chairman, National Indian Health Board and Chairman of the Seminole Tribe of Florida; Mr. Forrest Gerrard, Assistant Secretary for Indian Affairs, Dept. of the Interior, Bureau of Indian Affairs. Other invited speakers include Senator Frank Church, Chairman, Senate Special Committee on Aging; Congressman Claude Pepper, Chairman, Select Committee on Aging, U.S. House of Representatives; Senator John Melcher, Member, Senate Special Committee on Aging; Mr. Robert Benedict, U.S. Commissioner on Aging; Dr. Emery Johnson, Assistant Surgeon General, Director of the Indian Health Service; and Dr. George Lythcott, M.D., Assistant Surgeon General, Administrator of the Health Services Administration.

Other activities will include a Buffalo Barbecue Dinner sponsored by the Northern Cheyenne of Montana, Host Tribe, and a Traditional Style Show sponsored by the Billings Area Indian Health Board and the Billings, Montana, Conference Committee.

Traditional Dance following Buffalo Barbecue



Members of Navajo delegation

The following were notified and invited to attend the conference by direct mailing:

All United States Indian tribes
National Indian organizations
Major off-reservation Indian organizations and Urban Indian Centers in metropolitan areas
Administration on Aging, Central Office
Regional Programs—Directors on Aging
Bureau of Indian Affairs, Central Office and Regional Offices
Indian Health Service, Central and Regional Offices
Other Agencies and organizations working in the field of aging.

These and additional service provider agencies were asked to make staff available to give general support and to serve as resource persons in the workshop sessions.

Representatives participating as conferees or resource persons were from the following agencies:

Department of Health, Education and Welfare
Administration on Aging
Administration for Native Americans
Indian Health Service

Community Services Administration

Department of the Interior
Bureau of Indian Affairs

U.S. Department of Agriculture
Food and Nutrition Services
Extension Services
Farmers Home Administration

Department of Housing and Urban Development
Indian Desk

Department of Commerce
Census Bureau

The following national Indian organizations, which are a part of the existing Indian communications network, were informed of the conference and invited:

The National Tribal Chairmen's Association
The National Congress of American Indians
The National Indian Health Board
The Association of American Indian Physicians
The American Indian Nurses Association
The United Indian Planners Association
The National American Indian Safety Council.

During the entire planning process and months prior to the conference, any individual requesting conference information was sent a conference packet containing pertinent materials.

CONFERENCE PROGRAM

In line with the methodology and the conference objectives, the agenda was developed to include general assemblies featuring keynote speakers whose roles were pertinent to the field of aging. These assemblies were to promote opportunities for discussion, inquiries, and 'room for thought'.

In planning discussions, the planning committee had developed six major categories under the two designated foci:

1. Physical Well-Being
2. Mental Health
3. Home Health Care
4. Health Education
5. Environment (Housing)
6. Community Services

The conference program covered three consecutive days and was organized into three broad categories:

Status report and overview of existing resources to serve elderly Indians—their adequacy or inadequacy;

Determination of the additional or remedial action required;

Identification of the methodology to be employed to accomplish remedial action, provide continuous monitoring and evaluation of services, and effective future response to developing contingencies.

The workshop agenda was developed to offer opportunities for consideration of issues and problems, including a home health care training session and 17 reality-based workshops. Workshops designated after much discussion and interaction on conference objectives and planning were:

Long Term Care
Alternatives to Institutional Care
Nutritional Concerns
Social Security—Title XX (and Older Americans Act Title VI-Direct Funding)
Health Problems of the Elderly
Native Health Practitioners
Alcoholism and Drug Abuse

Health Education
Community Services
Patient Rights
Medicare and Medicaid
Training for Home Health Care
Spiritual Aspects of Aging
Tribal Specific Health Plans (P.L. 94-437)
Urban Specific Health Plans (P.L. 94-437)
Tribal Planning for Health Services
Housing
Potpourri

Each workshop was assigned one moderator and 3 to 5 panelists, as well as a volunteer assistant and one recorder. The recorders were provided tape recorders for backup purposes. Moderators were selected because of their experience and expertise in health or health-related areas. The moderators elicited statements of unmet needs, comparison of individual local conditions, and structured recommendations to be reported in the general assembly. Panelists contributed presentations based on specific expertise.

The panel presentations fell into two categories:

1. An overview of available services by agencies capable of providing direct services to elderly Indians, as well as reports by staff of agencies providing vital support services, such as the Indian Health Service, Bureau of Indian Affairs (Branch of Social Services), state and private agencies and organizations offering area or statewide complementary programs, etc.
2. Observations by Indian recipients of services for the elderly on the quality of current programs, unmet needs, and recommendations for improvement. Included within this category were Project Directors who are Indians and are serving Indian client groups.

In the conference evaluation, all workshops and workshop personnel received very positive comments. (Additional detail is contained in the Evaluation Section on Page 59.)

DISSEMINATION OF INFORMATION MATERIALS

Pertinent information material was disseminated in a separate exhibit area housed in the Media Room, which was set aside to show slides, films, and to exhibit written materials on aging programs, health and the environment related subjects, and the Indian Health Service Contract papers (see Appendices).

Ms. Vesta Starkey and Ms. Pat Lujan of the Albuquerque Area Indian Health Service, Social Services Branch, assembled the health pamphlets. Pamphlets and films displayed and distributed for use in the health education of service provider staffs and the Indian elderly and their families were:

Listen To Your Body
Everyday That You Live
The Truth About Diet and Arthritis
Cancer Facts for Women
Your Health Is Your Business
Concerned About Cancer? -Learn-
Straight Talk About Diabetes
What Everyone Should Know About Diabetes
Proper Diet Control for the Diabetic
How to Take Insulin
Diabetic: Emergency Measures
New Treats for Dieters
Arthritis: The Basic Facts
The Arthritis Foundation: What it is and What it does
What School Personnel Should Know
Living with Arthritis
It's Time to Cure Diabetes
Proper Site Selection and Preparation for Insulin Injection
What You Need to Know About Diabetic Children
You and Diabetes
Diet Delight Cookbook for Diabetic Children
Properly Understanding V-100 Insulin
Arthritis: Hay Esperanza
Assessment of Needs and Recommendations for Service Delivery System for the Elderly—Laguna Pueblo
PHS—Diabetic Overweight
Normal Diet
Patient Travel Identification Program—Alaska Area Native Health Service
Sisseton-Wahpeton Sioux Tribe—Services to the Elderly
Northern Cheyenne Tribe Elderly Housing Project and Health Services
Oneida Tribe of Indians of Wisconsin—Oneida Nursing Home
Gila River Nutrition Program
Yakima Tribal Health Surveillance Program

IHS Contract Papers (prepared under contract with the Indian Health Service) were:

Physical and Mental Health of Elderly American Indians
Data and Materials to Support a Community Education and Safety Program to Reduce Accidents among Elderly Indians
Environment of Elderly Native Americans
Continuum of Care

Films presented were:

There Is No One Word for Nursing Home (and Pamphlet) — Alaska Area Native Health Service

Recruitment — Arizona State University, School of Social Work

CONFERENCE PARTICIPATION

Conference participants fell into the following broad categories:

Representatives of the target group—American Indian elderly;

Representatives of tribal governments interested or involved in the provision of health and related services to the elderly;

Representatives of other Indian groups or organizations at the local, state or national levels with related interests;

Representatives of the local, area and national levels of the Indian Health Service and Bureau of Indian Affairs;

Representatives of agencies or organizations providing related services to elderly Indians;

Selected legislative leaders and staff members and representatives of the various levels of government from throughout the nation with the interest and capability to lend active support to efforts serving the needs of elderly American Indians;

Individuals or groups interested in providing complementary or supportive services to the Indian elderly.

The conference-related expenses of 140 participants from the target population, Indian elderly, were borne by the project. They were selected by their individual tribes or groups, were no less than 45 years, preferably 60 or over, individuals with a strong interest or involvement in the subject areas to be addressed at the conference, and unable to defray conference expenses from their own or other resources.

Individuals selected had to be in satisfactory physical condition to undergo without ill effects the strain of travel, including changes from accustomed climate, accommodations, food, etc. plus the exertion of active participation in conference deliberations. Additional criteria instituted by the National Conference Planning Committee for selection of sponsored participants were: be able to comprehend the objectives of the conference, must stay for the duration of the conference (3 days), and obligated to relay information gained at the conference to their own areas.

Sponsored participants were provided round trip air travel tickets from a central point of departure in their state to and from the conference site. Mileage for travel by automobile was allowed at a rate of 17¢ per mile per automobile to the extent that the total amount claimed did not exceed the cost of round trip air fare by the most direct route as specified above.

With regard to the selection of Indian elderly participants to be sponsored, the following considerations applied:

There are approximately 500 Indian tribes, villages, rancherias, etc. nationwide;

There are estimated to be 100 major urban Indian organizations;

Available resources allowed for a maximum of 150 slots.

After much deliberation, it was decided to allocate 12 sponsored participant slots to each of twelve (12) geographical areas. All federally-recognized Indian tribes and state reservations were encouraged to delegate at least one representative.

The Second National Indian Conference on Aging hosted delegates from 209 separate Indian tribes which represented 40 different states. All Indian tribes are listed as presented by the conferees. We have listed multiple tribal heritages of the conferees singly, unless there is a reservation or separate tribal organization representing two or more tribes.

We would like to acknowledge that there were visitors attending from Canada, but are unable to identify the Reserves represented.

The conferees from Canada and delegates from some state-recognized and terminated tribes attended the conference to compare their area aging programs and health services. We have listed the state-recognized and terminated Indian tribes since many Indians receive services along with the general population through the state in which they reside.

Alabama-Coushatta
Aleut
Apache (Camp Verde)
Apache (Ft. Mojave)
Apache (Ft. Sill)
Apache (Jicarilla)
Apache (Mescalero)
Apache (San Carlos)
Apache (White Mountain)
Arapaho (Oklahoma)
Arapahoe (Wind River)
Assiniboine (Ft. Peck)
Athabascan
Blackfeet
Caddo
Cahuilla
Cayuga
Cherokee (Eastern)

Cherokee (Oklahoma)
Cheyenne (Northern)
Cheyenne (Oklahoma)
Chemehuevi
Chickasaw
Chicopee
Chippewa
Chippewa-Cree (Ft. Belknap)
Chippewa (Bad River)
Chippewa (Fond du Lac)
Chippewa (Keweenaw Bay)
Chippewa (Lac du Flambeau)
Chippewa (Minnesota)
Chippewa (Pembina)
Chippewa (Red Cliff)
Chippewa (Red Lake)
Chippewa (Saginaw)
Chippewa (Sault Ste. Marie)
Chippewa (Sokaogon)
Chippewa (Turtle Mountain)
Chippewa (White Earth)
Choctaw (Mississippi Band)
Choctaw (Oklahoma)
Chumash
Clallam (Port Gamble)
Clallam (Lower Elwha)
Coeur d'Alene
Colorado River Indian Tribes
Colville Confederated Tribes
Comanche
Confederated Salish & Kootenai
Coushatta
Cree
Creek
Crow

Delaware (Kansas)
Delaware (Oklahoma)
Diegueño
Eskimo

Flathead
Gros Ventre

Haida
Hidatsa-Mandan (Ft. Berthold)
Hoopa
Hopi
Hualapai

Iroquois (Confederated)
Iowa (Nebraska)
Iowa (Oklahoma)

Karok
Kaw
Kickapoo (Kansas)
Kickapoo (Oklahoma)
Kiowa
Kumeyaay

Klamath

Luiseño
Lummi

Miami
Makah
Mandan
Maricopa
Menominee
Mesa Grande
Mesquakie
Micmac
Miccosukee
Mission Band
Missouri
Modoc
Mohawk (Akwesasne)
Mohawk (St. Regis)
Mono
Morongo
Munsee (Kansas)

Narrangansett
Navajo (New Mexico, Arizona, Utah)
Nez Perce
Nisqually
Nooksack

Ojibwa
Omaha
Oneida (New York)
Oneida (Wisconsin)
Osage
Otoe
Ottawa (Michigan)
Ottawa (Oklahoma)

Pala
Paiute
Paiute (Walker River)
Paiute (Pyramid Lake)
Papago
Pauma
Pawnee
Pechanga
Penobscot
Peoria
Pima
Pima-Maricopa (Salt River)
Pomo
Ponca
Potawatomi
Potawatomi (Citizens Band)
Potawatomi (Michigan)
Potawatomi (Prairie Band)
Pueblo (Acoma)
Pueblo (Cochiti)
Pueblo (Isleta)
Pueblo (Jemez)
Pueblo (Laguna)
Pueblo (Nambe)
Pueblo (Picuris)
Pueblo (Pojoaque)
Pueblo (San Felipe)
Pueblo (San Ildefonso)
Pueblo (San Juan)
Pueblo (Sandia)
Pueblo (Santa Ana)
Pueblo (Santa Clara)
Pueblo (Santo Domingo)
Pueblo (Taos)
Pueblo (Tesuque)
Pueblo (Zia)
Pueblo (Zuni)
Puyallup

Quapaw
Quechan
Quileute
Quinault

Resighini
Rincon

Sac and Fox (Iowa)
Sac and Fox (Oklahoma)
San Manuel
Santa Rosa
Seneca (Cattaraugus)
Seneca (New York)
Seneca (Tonawanda Band)
Seneca (Oklahoma)
Seminole (Florida)
Seminole (Oklahoma)
Shawnee (Absentee)
Shawnee (Eastern)
Shoshone
Shoshone (Wind River)
Shoshone-Bannock (Fort Hall)
Shoshone-Paiute (Duck Valley)
Shoshone-Paiute (Fallon)
Siletz
Sioux (Cheyenne River)
Sioux (Crow Creek)
Sioux (Devils Lake)
Sioux (Ft. Peck)
Sioux (Lower Brule)
Sioux (Oglala)
Sioux (Pine Ridge)
Sioux (Rosebud)
Sioux (Santee)
Sioux (Sisseton-Wahpeton)
Sioux (Standing Rock)
Sioux (Yankton)
Soboba
Spokane
Squaxin Island
Swinomish

Thlinget
Tolowa
Tonkawa
Torres-Martinez
Tsimpshean

Umatilla

Ute (Mountain)
Ute (Southern)
Ute (Uintah and Ouray)
Viejas
Walla-Walla
Warm Springs
Wyandotte
Washoe (Alpine)
Washoe (Pitt River)
Wichita
Winnebago (Nebraska)
Winnebago (Wisconsin)
Yurok
Yakima
Yavapai
Yaqui

States represented by the conferees attending the conference:

Alabama	Louisiana	New York
Alaska	Maine	North Carolina
Arizona	Maryland	North Dakota
California	Massachusetts	Oklahoma
Colorado	Michigan	Oregon
Connecticut	Minnesota	Rhode Island
Delaware	Mississippi	South Dakota
District of Columbia	Missouri	Texas
Florida	Montana	Utah
Georgia	Nebraska	Virginia
Idaho	Nevada	Washington
Illinois	New Hampshire	Wisconsin
Iowa	New Mexico	Wyoming
Kansas		

PROJECT RESULTS AND IMPLICATIONS

The general results of the conference project are as follows:

The maintenance and reinforcement of continuous communications between the NICOA Council and staff and the Administration on Aging and other agencies or organizations capable of providing supportive services to the Indian elderly. This should lead to more extensive use of the available resources in health and environment-related services.

The conference report, which lists: problems and unmet needs; recommendations for future or remedial action; and resolutions for proposed legislative changes or actions by federal agencies or local levels of service provider entities. Copies of the report will be provided to all conference participants, the National Aging Network, all agencies of the Bureau of Indian Affairs and Indian Health Service, tribal governments, major urban and national Indian organizations. Additionally, copies will be sent to Congressional Committees on Aging and Indian Affairs, the Library of Congress and the National Archives.

Improved communications with federal agencies, a climate of interaction in which to construct positive changes, and increased sensitivity to the needs and concerns of the Indian elderly.

Increased awareness of tribal leaders and tribal employees of services available for the elderly. In many cases, they are unaware of funding sources and of the various federal agencies capable of providing support for the older Indian people.

More information on P.L. 94-437, the Indian Health Care Improvement Act, and P.L. 93-638, the Indian Self-Determination Act.

Better understanding by the Indian elderly of health and health-related problems through education, e.g., IHS Contract Papers and pamphlets by different tribal health education and assistance programs. Knowledge gained from these written materials will be helpful to both agency and tribal representatives.

One noticeable result bringing unexpected benefits was the feeling of positive fellowship in the activities, informal interaction, and the formal display of tribal dress as part of the Indian and Alaskan Native heritage. This aided in reviving pride, emphasizing the uniqueness of Indian people, and underscored the importance of the elderly as carriers of Indian tradition.

The Second National Indian Conference on Aging resulted in increased interest in and sensitivity to the needs of the American Indian elderly with special emphasis on health-related issues. In addition, the conference reinforced recognition of the National Indian Council on Aging as a national Indian voice.

The general implication arising from the conference is that health care for the Indian elderly remains far from adequate. Specific areas of need, with suggested action to meet those needs, are listed in the Conference Recommendations and Resolutions which follow.

Members of over 40 tribes modeled their tribal dress at the Traditional Style Show following the Awards Banquet.

Recommendations for Action

Second National Indian Conference on Aging

1978

The following are problems and needs, with accompanying recommendations for action, which were identified by conference participants during the workshop sessions. They have been divided into five major subject areas: Health Care, Mental Health, Nursing Homes and Alternatives, Housing, and Transportation.

In addition to these specific problems and needs, the following concerns were repeatedly voiced by Indian Elders during the workshop sessions:

- The wish to be respected as an elder and treated as such as Indian tradition once taught.
- The desire to remain, if at all possible, in their Indian communities and cultures.
- The need for more nursing homes and hospitals for those not able to care for themselves.
- The desire to sustain and cultivate Indian cultures, and to be able to teach young Indians the Indian heritage.
- The need for more housing, weatherization and improvement of present dwellings.
- The need to upgrade the elderly's status with the Indian Health Service, providing them with better health care and making it easier for them to obtain prosthetic devices such as glasses, hearing aids and dentures.
- The need to organize Elderly Advisory Councils for their own programs.
- The desire of older Indians to be re-educated, thereby being able to develop skills to acquire more employment opportunities with programs within or outside of Title VII or CETA.
- The need for dissemination of information on aging programs as well as legislative updates to tribes and Indian organizations.
- The need for more Senior Citizens Centers and nutrition programs with the inclusion of native foods, whenever feasible or allowable.
- The need for more and better transportation for senior citizens because of the remote areas and distances between communities.
- The need to establish a Geriatrics Division in the Department of Health, Education and Welfare or Indian Health Service.

HEALTH CARE

Problem or Need	Recommendation for Action
The health needs of Indian people, and especially the elderly, far exceed those of the general public. There is a dire need of more and better health facilities in addition to services for dental care, alcoholism, eye/ear care, prosthetic devices, follow-up care, etc. Lack of understanding by state agencies of these problems results in inadequate funding for these services and facilities.	Indian Health Boards must ensure that excellent quality care is provided professionally, and adequately, to all Indian people. Additionally, IHS must upgrade the status of elderly in health priorities and plan a comprehensive health system as advocated through Congressional intent with passage of P.L. 93-638 and 94-437. Broaden the scope of section 401, Title IV, P.L. 94-437, Medicaid provisions, to include participation of all types of IHS facilities/services/programs rather than limiting participation to hospitals and skilled nursing facilities.

HEALTH CARE (continued)

Problem or Need	Recommendation for Action
At present, seventeen IHS hospitals do not meet state accreditation standards. Some of the deficiencies within these institutions are: staffing problems, equipment and plant deficiencies, billing procedures, etc.	Provision of adequate funding for administrative expenses of state Medicaid agencies and IHS. Simplification of billing, collecting and cost accounting procedures for Medicaid program for IHS providers. (Training of hospital staff could be done on a one-to-one basis by program personnel.) Removal of restrictive language limiting time of IHS facilities' participation in Medicare/Medicaid programs, which appears in the President's FY 1979 Budget. Extension of provisional certification waiver period because of the time lapse involved in the return of reimbursements to IHS for correcting deficiencies. Permit IHS to use federally derived, quantitative standards for determining staffing problems and other deficiencies so that reimbursements may be used to address these matters.
Information on Medicare/Medicaid programs is not accessible enough to Indian people, elderly in particular, leaving them ignorant of their entitlement to these benefits in IHS facilities.	Urge training programs by HEW to increase understanding and participation by eligible Indians in health care benefit programs. Special training sessions for Public Health personnel or community health representatives to act as outreach workers in dissemination of information on health care benefits to Indian people, especially for those about to receive treatment. Wider distribution of health care benefits should be more strongly effected by administrators of Medicare/Medicaid programs.
Many Indian elderly have little or no access to health facilities because of transportation problems and isolation.	Construction of IHS facilities should be encouraged near Indian communities and remote areas.
Recruitment of medical personnel for Indian communities has not been dealt with realistically enough; a large cultural gap and communications barrier exists between the non-Indian doctor and elderly Indian patient.	There should be a further development of the Medical Professions Recruitment Act to encourage Indians to enter health-related professions. Liaison people (interpreters, native healers and practitioners) should be provided within IHS facilities in order to promote a better understanding of elderly's problems. Use of such personnel could also serve to combine conventional medical treatment with traditional techniques to more fully treat the entire individual.

HEALTH CARE (continued)

Problem or Need	Recommendation for Action
Major significant health problems of the elderly American Indian include: diabetes, arthritis, high blood pressure, pneumonia, and nutritional problems.	Needed and appropriate research would include the development of culture-specifications of data permitting comparison between Indian elderly and non-Indian elderly, in order to research factors which place Indian people in position of high risk for the development of certain diseases.
A large majority of the Indian elderly are simply not visiting health facilities even though they may have a very significant problem. (One factor involved might be that youthful patients are usually given priority treatment.)	Conduct a study of different areas to see what the mechanisms and reasons are for the different utilization of services. Set aside certain days of the week for the elderly to receive health services. Primary screening of patients could be done in Senior Citizens' Centers.
Serving non-Indian spouses and, in some cases, non-Indian children from previous marriages in IHS facilities has created problems by displacing eligible enrolled tribal members and reducing appropriations designed specifically for them.	Urge IHS and BIA to revise the criteria for eligibility for medical and dental services, denying services to non-Indian individuals.
Eligibility for services poses a problem in various parts of the country as health care benefits vary from state to state.	The criteria for these benefits should be more equally distributed, regardless of residence status, for both direct and indirect care.
For those patients choosing a private physician, no acceptable program exists that would mandate a physician's reimbursement fee schedule as established by Medicare.	A further development of fee schedule needs to be established to create guidelines for Medicare users.
Montana and North Dakota are the only states not funding IHS facilities at present.	Enforce regulations related to Medicaid agencies' non-compliance so that eligible Indians residing in these two states are not denied their entitlements in IHS facilities. Government officials should expedite implementation of Title IV by funding the respective states' Medicaid agency for administrative costs until other means for covering these costs are found.
Arizona remains the only state without a Medicaid program.	Efforts are still being made to include this state.

MENTAL HEALTH

Problem or Need	Recommendation for Action
Many of the younger Indians have adopted the dominant society's ways and, in the process, have lost a great deal of their own culture, language, etc. As a result, the elders are no longer considered the most important members of their society and are often neglected, causing them loneliness and depression.	Efforts should be supported to help the elderly retain a sense of physical, mental, and spiritual well-being, as well as to become an integral part of their community again. The development of Senior Citizens' Centers or clubs should be encouraged to promote good mental health. The curriculum of activities might provide opportunities such as the following: (1) Social (2) Educational (3) Recreational (4) Employment (paid or on a volunteer basis) Additionally, transportation should be made available to elderly so they may participate in these activities. School system needs to recognize the Indian culture and allow for it within the educational process so that the "Indian way" may be kept alive for succeeding generations. Community programs should be encouraged for younger Indians to learn and participate in their native cultures' knowledge of medicines, language, etc. with the help of tribal elders. Documentation and recording of such information should also be stored for future generations' needs.
Placement of Indian elderly in nursing homes, far removed from their natural environment, often causes emotional shock due to separation from their familiar surroundings.	A strong system of support, offering live-in help if necessary, should be established to enable more elderly to remain at home. As a last resort, nursing homes should be provided on or near reservations.
Methods of treatment for mental disorders are not adequately geared to meet the elderly Indians' needs.	Treatment programs should be designed to provide relief from a hostile world with personnel of similar cultural background to implement and staff them.
Alcoholism and drug abuse problems afflict many elderly Indians: treatment programs often discriminate against the elderly population.	Treatment of the entire individual is important; where there is a sizeable elderly population, separate facilities and counseling techniques for them. Community education programs should be established for recognizing, dealing with and preventing these disorders. State officials should discourage building of liquor establishments near reservations. Institution of more security for non-afflicted family members should be encouraged within Indian communities; offenders should be required to get help.

NURSING HOMES AND ALTERNATIVES

Problem or Need	Recommendation for Action
With very few exceptions, no long term care facilities exist on reservations. Nursing homes are urgently needed for elderly Indians as the younger generations' value system no longer regards the elder as the most respected member in the community and tribe. This can pose problems when an elder is cared for over an extended period of time in the home of relatives. As a result of this, the elderly are increasingly being placed in off-reservation nursing homes, causing them a great deal of emotional trauma due to separation from their natural environment.	Support building of nursing homes on reservations to be owned and operated by tribes for their infirm. These facilities should take into account local culture and be built and staffed accordingly. (1) Incorporation of nursing homes should be made into tribal specific health plans to obtain direct funding. (2) Sources of help on staffing and training of personnel could come from the American Indian Nurses' Association, direct contact with other reservation hospitals, closer work with IHS, and other resources available in locale. (3) Study programs in existence in order to expand types of care offered in these facilities. (4) Follow guidelines set by Medicare in setting state standards for these facilities. Day care centers and Multi-Purpose Indian Senior Citizens' Centers, with personnel from a similar background, should be established within Indian communities to aid in addressing these needs.
Lack of information on nursing care programs and funding sources impedes the implementation of programs in this area of health care.	Contract report, "Alternatives for Planning a Continuum of Care for Elderly American Indians" (included in this report), is useful in formulating plans for such programs.
Many elderly live alone and usually have no access to many needed services that would enable them to lead a more comfortable and secure life.	A stronger system of support should be established to maintain these people at home. Among the services offered to those elderly well enough to remain at home would be: (1) Shopping and housecleaning services (2) Visits by home health aides (HHAs) and Community Health Representatives (CHRs) (3) Transportation for medical and other complementary services (4) "Meals on Wheels" (5) Telephone service (6) Police protection (7) Legal services (8) Referral services for other sources of help (9) Possibly a newsletter
Outreach workers often have to travel great distances to reach their clientele and do not presently have sufficient mileage allowance made for their distribution of services.	More realistic mileage allowance should be made for outreach workers in view of the fact that their services encompass large geographical distances.

NURSING HOMES AND ALTERNATIVES (continued)

Problem or Need	Recommendation for Action
Reservation hospitals are lacking in qualified home health aides (HHAs) for home nursing care. Duties for personnel should be more specifically outlined in a home health care situation.	Recommendation by BIA to follow guidelines set by Medicare/Medicaid programs in care of custodial patients, with HHA's receiving a minimum of six weeks training.

HOUSING

Problem or Need	Recommendation for Action
The average, healthy Indian elder is a proud and independent citizen, who in his later years would rather remain in his own home than live with relatives or be placed in a nursing home. This is not always feasible as a result of cost of living increases, disability in later years and the safety factors involved.	Agencies should consider assisting the extended family groups, i.e., third and fourth generations, in funding larger homes. These families should also have the assistance of other supportive services in caring for their elderly. Options should be open to allow elderly to select the type of housing or lifestyle desired, for example: (1) individual home owner (2) congregate or apartment style (3) extended family larger home Building design should take into account the needs of the handicapped elderly. Safety should be a major consideration. If these "extras" cost more, then additional dollars should be appropriated. (A separate but closely related home-living need is the extended care facility or nursing home within Indian communities.) Building standards should be flexible enough to allow tribes to tailor homes to cultural, physical, safety and comfort needs of the elderly.
Many elderly Indians own their own homes, but as a result of health problems or expenses they are usually poorly maintained and in need of much repair. Many of their homes lack electricity, water, sanitary facilities, and need winterization and weatherization.	Direct grants should be made available to tribes and Indian communities to initiate repair programs; options should include low cost or no cost housing.
Housing programs are not generally made known to Indians; there is a great need for more trained people who can deal with Indian housing programs. As a direct result of this, in 1977, less than 1% of home loans were made to Indians.	Institution of a full time housing agency for Indian housing programs, at the state level, that would administer directly to their needs and serve as a source of information on housing programs. A program of education should be instituted to acquaint the elderly Indian with laws governing housing authorities. This might further serve to give them a more direct say in housing programs designed for them.

HOUSING (continued)

Problem or Need	Recommendation for Action
Some federal programs that assist with housing problems are too restrictive in their regulations and, as a result, disqualify many low income elderly individuals.	Direct funding to Indian communities should be made available to institute specific programs for elderly Indians to address their particular housing needs.

TRANSPORTATION

Problem or Need	Recommendation for Action
Transportation remains a major area of need for the elderly Indian population. The lack of it inhibits acquisition of the most basic items deemed necessary for their well-being. Further compounding this situation are poor road conditions, lack of communications systems, public conveyances and isolation.	Transportation should receive priority funding from AoA and related agencies to ensure availability of a better quality of life.

Kenneth Cody, President of the Navajo Nation Council on Aging, leading Conference participants in limbering up exercises.

Resolutions

Contained in this section are the twenty-one resolutions of the thirty-one submitted which were adopted and endorsed by the conference body of the Second National Indian Conference on Aging in Billings, Montana, on August 18, 1978.

The members of the Resolution Committee conducted the intake, review and later, edited and presented the included resolutions. The following were the members of the Resolution Committee selected by the NICOA Chairman, Executive Director and Board of Directors:

Walter Moffett, (Nez Perce) Chairman; Board Treasurer —Portland Area
Sherman Lillard, (Eastern Cherokee) Board Secretary—Central Area
Bette Scott, (Winnebago)—Aberdeen Area (Council Member)
Robert Holmes, (Ottawa)—Phoenix Area (Council Member)

We have provided the reader a synopsis of the resolutions endorsed. As you will see, in the actual resolutions, there were a few which contained many parts asking for action of different agencies. The synopsis will show a breakdown of the requests and needed support.

Department of Health, Education and Welfare

- Requests the lowering of the eligibility age requirement for the Title VII Feeding Program of the Older Americans Act from 60 years of age to 45 years of age.
- Supports the need to insure the availability of additional and sufficient funds for the Title V Program of the Older Americans Act, Multi-Purpose Senior Citizens Center construction.
- Requests that the regulation under Title IX of the Older Americans Act be amended to specify use of county population figures for purposes of hiring minorities.
- Requests that IHS be directed to establish policy consistent in addressing Indian elderly health needs expressed at this national hearing and give recognition to Indian elders.
- Urges that all officials and all concerned tribes to unite in support of IHS's request for supplementary funding for the care of elderly American Indians.
- Requests the Administration on Aging to include the New England Elderly Indians Advisory Council in any changes of the language of the Older Americans Act.
- Urges IHS to revise the criteria of eligibility for medical and dental services thus denying services to non-Indian spouses.
- Supports the proposed Indian Social Services Act of 1978 for Congressional passage to provide direct funding to Indian tribal governments.
- Requests that Individual Indian Monies, (IIM) be exempt from State and Federal eligibility consideration for welfare and other general assistance programs as presently Social Security penalizes Indian citizens for use of their trust income derived from their land and property.
- Requests the Director of IHS to use Medicare and Medicaid reimbursements to help facilities attain compliance with accreditation standards.
- Supports providing AoA the required authority and funding to employ the staff with expertise in service to the national Indian aging community which is required to implement the provision of Title VI of S. 2850.
- Requests the Administration on Aging to insure the rights of State Indian Councils on Aging to have direct input into the selection of representatives to State Advisory Councils on Aging.
- Requests IHS to build new hospital facilities and to expand existing facilities to provide necessary care and adequate health services.
- Urges the Administration on Aging to make provisions for transportation needed by elderly Indians to acquire medical and social services, to purchase food and other necessities that assure a normal, healthy life. (OAA, Title III)
- Requests the Administration on Aging to provide for more nutritional services through Senior Citizens' Centers and programs delivering meals to elderly Indians, as many suffer from malnutrition due to low income, inaccessibility to retail stores due to remoteness of homes and poor diets. (OAA, Title III)

Department of the Interior

- Requests the Bureau of Indian Affairs to support Indian tribes in their efforts to establish nursing homes on their reservations, rectifying the lack of sufficient funds and acknowledging responsibility for Indian elderly.
- Requests the Bureau of Indian Affairs to revise the criteria of eligibility for General Welfare Assistance Programs denying services to non-Indian spouses.
- Urges that provisions of the Bureau of Indian Affairs Manual 66.IAM, 3.1.12A (1)(2) be enforced on a national level to provide burial assistance for Indian elders. Denial places extreme hardship on the remaining family.

Department of Housing and Urban Development

- Requests that low-cost individual housing, group or shelter homes, Senior Citizen's Centers and other service facilities must be constructed to meet social, physical and cultural needs of the Indian elderly.
- Urges that HUD make provisions to assist Indian elderly in attaining a suitable environment as a large number of Indian elders do not even have running water or electricity, which is taken for granted by the majority of people in the United States.

Department of Labor

- Requests the Department of Labor (DOL) to require states to comply with CETA regulations insuring that a percentage of slots allocated to the elderly be maintained and utilized.
- Urges the DOL to maintain appropriations at the present levels as some elderly Indians in various cities receive quality comprehensive social services, homemaking services and employment through CETA, Title I Public Service Employment Programs.

Department of Transportation

- Requests that, since most citizens 65 years of age and older have low incomes, they should be allowed lower costs of travel by airlines, trains and buses and be treated as regular, full-paying passengers, as well as not having to travel on stand-by basis.

Action Agency

- Requests that the stipend rate of P.L. 93-113, Title II, the National Older Americans Volunteer Programs, be adjusted from $1.60 to $2.00 per hour in conformance with ACTION's stated desire for consistent and effective operations, as well as lowering the age requirement to 55 years of age.
- Urges that the ACTION Volunteer Agency, Foster Grandparents Program, extend involvement of their meaningful programs to other Alaskan Native and American Indian Tribes, who could benefit immensely by providing Indian youths a close and positive association with Indian elderly.

State and Local Levels

- Requests the Governors of North Dakota and Montana to expedite implementation of Title IV by immediately funding the respective states' Medicaid Agency for administrative costs.
- Urges all Tribal Councils to encourage their Community Health Representatives, CETA participants, Housing Counselors, etc., to establish and maintain close personal rapport with elderly clients after conferees heard reports of tribal employees, who may be insensitive and uncommunicative with the elderly who are deserving of respect and attention.
- Urges Tribal Councils to seek participation in training programs provided by HEW Regional Offices to assure greater understanding of and participation by all eligible Indians in Social Security Act Programs, including Medicaid and Medicare.
- Requests all Indian tribes, elected officials and organizations of and for the elderly to unite in support of the Indian Health Service's request for supplementary funding for the care of elderly American Indians.

National Indian Council on Aging, Inc.

- Wishes the NICOA Board of Directors to consider the State of Oklahoma as the site of the Third National Indian Conference on Aging, to be hosted by the Oklahoma Indian Council on Aging, Inc.

Conference participants filling up at Buffalo barbecue sponsored by NICOA and Northern Cheyenne Tribe.

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CONFERENCE RESOLUTION NO. 78-1

WHEREAS, the Fort Peck ANA Office has met with the reservation-wide Senior Citizen groups to assess their needs, and

WHEREAS, based upon their input, it has been stated that two major areas of concern are: 1) The lowering of the eligibility age requirement for the Title VII Feeding Program of the Older Americans Act from 60 years of age to 45 years of age, and 2) The need to insure the availability of additional and sufficient funds for the Title V Program of the Older Americans Act ("Multi-Purpose Senior Citizens" construction),

NOW, THEREFORE, BE IT RESOLVED, that the Second National Indian Conference on Aging does hereby urgently request, the Congress of the United States, the Secretary of the Department of Health, Education and Welfare, and the Commissioner of the Administration on Aging, to begin immediately to include the two concerns listed above in amendments to the Older Americans Act to comply with this resolution.

Certification

The above Conference Resolution No. 78-1, having been duly introduced at the plenary session of the Second National Indian Conference on Aging on August 18, 1978, in Billings, Montana, was adopted by unanimous vote, indicating full support of its content.

/s/ Walter L Moffett

Walter Moffett
Chairman
Resolutions Committee

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CONFERENCE RESOLUTION NO. 78-2

WHEREAS, the existing regulations for Senior Employment Opportunities under Title IX of the Older Americans Act specify hiring of minorities based on state-wide population, and

WHEREAS, population figures are taken only every 10 years, causing inaccurate population figures and percentages, and

WHEREAS, accurate population figures are unavailable on a state-wide basis,

NOW, THEREFORE, BE IT RESOLVED, that the wording of the regulation under Title IX of the Older Americans Act be amended to specify use of county population figures for purposes of hiring minorities.

Certification

The above Conference Resolution No. 78-2, having been duly introduced at the plenary session of the Second National Indian Conference on Aging on August 18, 1978, in Billings, Montana, was adopted by unanimous vote, indicating full support of its content.

/s/ Walter L Moffett

Walter Moffett
Chairman
Resolutions Committee

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CONFERENCE RESOLUTION NO. 78-3

WHEREAS, the Albuquerque Service Unit Indian Health Board represents nine (9) Indian tribes; namely, the Pueblos of Acoma, Laguna, Isleta, Jemez, Santa Ana, Zia, Sandia, and the Navajo Chapters of Canoncito and Alamo pertinent to Indian Health, and

WHEREAS, the Albuquerque Service Unit Indian Health Board is responsible to assure that excellent quality health care is provided professionally and adequately to our Indian people, and

WHEREAS, the needs of the Indian elderly is prominent within a planned comprehensive health system as advocated through congressional intent with passage of Public Law 93-638 and 94-437, and

WHEREAS, the elderly Indian through sovereign rights shall remain a strong integral force due all respect, honor, and dignity within our society, reflective of significant contributions past, present and future.

NOW, THEREFORE, BE IT RESOLVED, that the Albuquerque Service Unit Indian Health Board and its delegation of Indian people within the Albuquerque Service Unit strongly stand in support of all testimony submitted in behalf of the Indian elderly, and

BE IT FURTHER RESOLVED, that the Indian Health Service, in total, hereby be directed to establish policy consistent in addressing needs expressed at this national hearing and recognition be given to our elder Indian participants.

Certification

The above Conference Resolution No. 78-3, having been duly introduced at the plenary session of the Second National Indian Conference on Aging on August 18, 1978, in Billings, Montana, was adopted by unanimous vote, indicating full support of its content.

/s/ Walter L Moffett

Walter Moffett
Chairman
Resolutions Committee

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CONFERENCE RESOLUTION NO. 78-4

WHEREAS, the Gila River Indian Community and all other Indian tribes are desirous of of quality care services for their elderly and infirm; and

WHEREAS, the Bureau of Indian Affairs has informed the Indian Health Service that it can no longer assume financial responsibility for intermediate care of indigent elder citizens in nursing homes; and

WHEREAS, such care is critical especially for those unable to care for themselves or those who cannot be privately cared for by relatives; and

WHEREAS, Indian Health Service has informed the tribe (tribes) that it is presently unable to assume its legal responsibility in this area and will not be able to do so in the future unless its request for supplemental funding is approved.

NOW, THEREFORE, BE IT RESOLVED, that the Second National Indian Conference on Aging urgently requests that all our elected officials and all concerned tribes unite in support of Indian Health Service's request for supplementary funding for the care of elderly Native Americans.

BE IT FURTHER RESOLVED, that the elderly organizations, the Council, all other concerned organizations, Bureau of Indian Affairs, and Indian Health Service, aid in this effort to provide services to elderly Native Americans.

Certification

The above Conference Resolution No. 78-4, having been duly introduced at the plenary session of the Second National Indian Conference on Aging, on August 18, 1978, in Billings, Montana, was adopted by unanimous vote, indicating full support of its content.

/s/ Walter L Moffett

Walter Moffett
Chairman
Resolutions Committee

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CONFERENCE RESOLUTION 78-5

WHEREAS, the Comprehensive Employment and Training Act regulations provide for the employment of elderly persons.

NOW, THEREFORE, BE IT RESOLVED that the Second National Indian Conference on Aging requests that states be required to comply with the CETA regulations insuring that the percentage of slots allocated to the elderly be fully utilized.

Certification

The above Conference Resolution No. 78-5, having been duly introduced at the plenary session of the Second National Indian Conference on Aging on August 18, 1978, in Billings, Montana, was adopted by unanimous vote, indicating full support of its content.

/s/ Walter L Moffett

Walter Moffett
Chairman
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CONFERENCE RESOLUTION 78-6

WHEREAS, The Committee for the Hopi Elderly has been formally organized by adopting Articles and By-Laws for the purpose of reviewing, researching and making recommendations to the Hopi Tribal Council on issues related to the elderly of the Hopi Tribe; and

WHEREAS, the Hopi Elderly Committee recognizes its duty to meet the special needs of the Hopi Senior Citizens, including transportation, housing, nutrition, home care, senior citizen centers and especially the need for an extended skilled care facility on the Hopi reservation; and

WHEREAS, the nearest nursing home facility available is 300 miles from the center of the Hopi reservation and that it is becoming increasingly difficult to find available space in these homes for placement of the eligible Hopi elderly because of limited beds and lack of sufficient funding available for Bureau of Indian Affairs Social Services; and

WHEREAS, the placement of Hopi elderly in off-reservation nursing homes is a separation from their traditional and cultural ties of the extended family unit causing traumatic experiences for them, resulting in serious consequences on their health and life expectancy; and

WHEREAS, the Hopi Health Committee has reviewed this matter and supports the efforts of the Committee for the Hopi Elderly to present this item to the National Indian Council on Aging, Inc. for acceptance and endorsement at their Second National Indian Conference on Aging at Billings, Montana.

NOW, THEREFORE, BE IT RESOLVED that the Second National Indian Conference on on Aging supports the Hopi Tribe, and all other tribes who have such needs, in their efforts to establish nursing homes on the Reservations.

Certification

The above Conference Resolution No. 78-6, having been duly introduced at the plenary session of the Second National Indian Conference on Aging on August 18, 1978, in Billings, Montana, was adopted by unanimous vote, indicating full support of its content.

Walter Moffett
Chairman
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CONFERENCE RESOLUTION NO. 78-7

WHEREAS, the Oklahoma Indian elderly delegation and representatives of the Oklahoma Indian Council on Aging have requested of the National Indian Council on Aging to hold its Third National Indian Conference on Aging in Oklahoma in 1980.

NOW, THEREFORE, BE IT RESOLVED, that the Second National Indian Conference on Aging urges the National Indian Council on Aging to consider the invitation of the Oklahoma delegation to hold its third national conference in Oklahoma, the actual site to be determined by the Oklahoma Indian Council on Aging.

Certification

The above Conference Resolution No. 78-7, having been duly introduced at the plenary session of the Second National Indian Conference on Aging on August 18, 1978, in Billings, Montana, was adopted by unanimous vote, indicating full support of its content.

Walter Moffett
Chairman
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CONFERENCE RESOLUTION NO. 78-8

WHEREAS, the Oklahoma Indian elderly delegation and representatives of the Oklahoma Indian Council on Aging and other state Indian Councils on Aging have had difficulty with their respective State Council on Aging in selection of the Indian representative on the State Council on Aging.

NOW, THEREFORE, BE IT RESOLVED that the Second National Indian Conference on Aging request the Administration on Aging to insure the right of "State Indian Councils on Aging" to have direct input in the selection of representatives on State Councils on Aging.

Certification

The above Conference Resolution No. 78-8, having been duly introduced at the plenary session of the Second National Indian Conference on Aging on August 18, 1978, in Billings, Montana, was adopted by unanimous vote indicating full support of its content.

/s/ Walter L Moffett

Walter Moffett
Chairman
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CONFERENCE RESOLUTION NO. 78-9

WHEREAS, the life expectancy of citizens other than Native Americans is 72-78 years, and

WHEREAS, the life expectancy of the Native American has been determined to be 46 years from date of birth,

WHEREAS, the New England Elderly Indian Advisory Council acknowledges that the Older Americans Act has established the age of 60 as its minimum age to participate in programs funded by this Act.

WHEREAS, the Older Americans Act does exclude many of the Native Americans from participation and employment of services because of the life expectancy rate and the age limit of the Act.

NOW, THEREFORE, BE IT RESOLVED that the New England Elderly Indians Advisory Council seeks the aid of the Administration on Aging in having the age limit of the Act lowered to age 50 for Native Americans and be it further resolved that the New England Elderly Indians Advisory Council be included to participate in any changes of the language of the Older Americans Act.

Certification

The above Conference Resolution No. 78-9, having been duly introduced at the plenary session of the Second National Indian Conference on Aging on August 18, 1978, in Billings, Montana, was adopted by unanimous vote, indicating full support of its content.

/s/ Walter L Moffett

Walter Moffett
Chairman
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CONFERENCE RESOLUTION NO. 78-10

WHEREAS, Indian Health Service programs have been designed to assist Indian people living on Federally recognized reservations, and

WHEREAS, these programs have been provided for tribally-enrolled members, regardless of their residence, and that it is incumbent upon the Indian Health Service to provide these services, viz., medical and dental; and

WHEREAS, these services have been provided to non-Indian spouses of Indian women, the non-Indian male as head of the household has in some cases non-Indian children by previous marriages have been included and declared eligible for these medical and dental services, displacing eligible enrolled Tribal members and has greatly reduced appropriations designed for enrolled Tribal members.

NOW, THEREFORE, BE IT RESOLVED that the Second National Indian Conference on Aging supports the recommendations introduced at the Second National Indian Conference on Aging urging that IHS revise the criteria for eligibility for medical and dental services, denying services to these non-Indian spouses.

Certification

The above Conference Resolution No. 78-10, having been duly introduced at the plenary session of the Second National Indian Conference on Aging on August 18, 1978, in Billings, Montana, was adopted by unanimous vote, indicating full support of its content.

Walter Moffett
Chairman
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CONFERENCE RESOLUTION NO. 78-11

WHEREAS, the Bureau of Indian Affairs, General Welfare Assistance Programs have been designed to assist Indian people living on federally-recognized reservations,

WHEREAS, these programs have been provided for tribally-enrolled members, regardless of their residence, and it is incumbent upon the BIA, General Welfare Assistance Programs to provide these welfare services, and

WHEREAS, these services have been provided to non-Indian spouses of Indian women, the non-Indian male as head of the household has in some cases non-Indian children by previous marriages have been included and declared eligible for these medical and dental services, displacing eligible enrolled tribal members and has greatly reduced appropriations designed for the enrolled tribal members.

NOW, THEREFORE, BE IT RESOLVED that the Second National Indian Conference on Aging supports the recommendations introduced at the Conference urging the BIA to revise the criteria for eligibility for General Welfare Assistance Programs, denying services to those non-Indian spouses.

Certification

The above Conference Resolution No. 78-11, having been duly introduced at the plenary session of the Second National Indian Conference on Aging on August 18, 1978, in Billings, Montana, was adopted by unanimous vote, indicating full support of its content.

Walter Moffett
Chairman
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CONFERENCE RESOLUTION NO. 78-12

WHEREAS, most 65 and older citizens are low income, and should be allowed a lower cost of travel by airlines, trains and buses.

NOW, THEREFORE, BE IT RESOLVED, that passengers traveling on such reduced costs be treated as regular, full-paying passengers, and not have to travel on a stand-by basis.

Certification

The above Conference Resolution No. 78-12, having been duly introduced at the plenary session of the Second National Indian Conference on Aging on August 18, 1978, in Billings, Montana, was adopted by unanimous vote, indicating full support of its content.

Walter Moffett
Chairman
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CONFERENCE RESOLUTIONS NO. 78-13

WHEREAS, the conferees at the Second National Indian Conference on Aging heard reports that some tribal employees may be insensitive and uncommunicative with our Indian elderly, and

WHEREAS, the Indian elderly deserve respect and attention from the tribal employees, as well as from the general Indian population,

NOW, THEREFORE, BE IT RESOLVED that the Second National Indian Conference on Aging does hereby urge all Tribal Councils to encourage their employees such as CHR's, CETA participants, Housing Counselors, etc., to establish and maintain close personal rapport with the elderly clients in their respective reservation programs.

Certification

The above Conference Resolution No. 78-13, having been duly introduced at the plenary session of the Second National Indian Conference on Aging on August 18, 1978, in Billings, Montana, was adopted by unanimous vote, indicating full support of its content.

/s/ Walter L Moffett

Walter Moffett
Chairman
Resolutions Committee

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CONFERENCE RESOLUTION NO. 78-14

WHEREAS, some American Indians have been denied burial assistance by the Bureau of Indian Affairs, and/or Indian Health Service, and

WHEREAS, such denial places an extreme hardship on families of the deceased, and

WHEREAS, such assistance can be provided to families under the Bureau of Indian Affairs Manual 66.IAM, 3.1.12A(1) (2).

NOW, THEREFORE, BE IT RESOLVED that the Second National Indian Conference on Aging urges that the provisions be enforced on a national level as provided by above referenced BIA Manual.

Certification

The above Conference Resolution No. 78-14, having been duly introduced at the plenary session of the Second National Indian Conference on Aging on August 18, 1978, in Billings, Montana, was adopted by unanimous vote, indicating full support of its content.

Walter Moffett
Chairman
Resolutions Committee

NATIONAL INDIAN CONFERENCE ON AGING

Sponsored By The

NATIONAL INDIAN COUNCIL ON AGING, INC.

P.O. BOX 2088 • ALBUQUERQUE, NEW MEXICO 87103 • (505) 766-2276

CONFERENCE RESOLUTION NO. 78-15

WHEREAS, the Second National Indian Conference on Aging is concerned that the Indian elderly and Indian people of all ages have full access to social services as administered by the Department of Health, Education and Welfare, and other federal governmental funding sources and,

WHEREAS, the National Tribal Chairmen's Association has developed the Indian Social Services Act of 1978, an Amendment of Title XX of the Social Security Act to provide direct funding to Indian governments over and above the present Title XX allocations to states.

NOW, THEREFORE, BE IT RESOLVED that the Second National Indian Conference on Aging hereby supports the proposed Indian Social Services Act of 1978 for Congressional passage.

BE IT FURTHER RESOLVED that copies of this resolution be sent immediately to the Secretary of Health, Education and Welfare and the President of the United States, urging their support for enactment of this amendment.

Certification

The above Conference Resolutions No. 78-15, having been duly introduced at the plenary session of the Second National Indian Conference on Aging on August 18, 1978, in Billings, Montana, was adopted by unanimous vote, indicating full support of its content.

Walter Moffett
Chairman
Resolutions Committee

19

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CONFERENCE RESOLUTION NO. 78-16

WHEREAS, The Social Security regulations now provide that any individual may have no more than $1,500.00 per year ($2,250.00 per couple) without jeopardizing their benefits and,

WHEREAS, Social Security now arbitrarily penalizes Indian citizens from use of their individual Indian monies (IIM) without regard to their own Social Security regulations and,

WHEREAS, this is an infringement on each Indian person's individual rights to income derived from his land and property.

NOW, THEREFORE, BE IT RESOLVED, that IIM funds should be exempt from State and Federal regulations for welfare and other general assistance programs.

Certification

The above Conference Resolution No. 78-16, having been duly introduced at the plenary session of the Second National Indian Conference on Aging on August 18, 1978, in Billings, Montana, was adopted by unanimous vote, indicating full support of its content.

/s/ Walter L Moffett

Walter Moffett
Chairman
Resolutions Committee

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CONFERENCE RESOLUTION NO. 78-17

WHEREAS, Elderly Native American Indian residents of various cities have received quality comprehensive social services and homemaking services through the utilization of the CETA, Title VI, Public Service Employment Program.

NOW, THEREFORE, BE IT RESOLVED that the Second National Indian Conference on Aging hereby requests that American Indian appropriations be maintained at the present level.

Certification

The above Conference Resolution No. 78-17, having been duly introduced at the plenary session of the Second National Indian Conference on Aging on August 18, 1978, in Billings, Montana, was adopted by unanimous vote, indicating full support of its content.

Walter Moffett
Chairman
Resolutions Committee

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CONFERENCE RESOLUTION NO. 78-18

WHEREAS, Title IV, P.L. 94-437 provides Indian people an opportunity to use their Medicare and Medicaid entitlements in Indian Health Service facilities, and

WHEREAS, Indian Health Service has been authorized to receive and use reimbursements for services rendered in these facilities to Medicare and Medicaid eligible Indians, full implementation of this Act has been delayed and requires both legislative and administrative efforts to maximize the intended benefits.

NOW, THEREFORE, BE IT RESOLVED that the Secretary of the Department of Health, Education and Welfare be requested to take appropriate action to:

1) Provide adequate funding for administrative expenses of state Medicaid agencies and Indian Health Service;
2) Broaden the scope of Section 401, Title IV, P.L. 94-437, the Medicaid provisions, to include participation of all types of IHS facilities/services/programs rather than restricting participation to hospitals and skilled nursing facilities;
3) Permit state Medicaid agencies by whatever means necessary to simplify billing, collecting and cost accounting procedures for IHS providers, for example, utilization of all inclusive rates used by Medicare both for inpatient and outpatient charges;
4) Remove restrictive language limiting time of IHS facilities' participation in the Medicare and Medicaid programs that appears in the President's FY-1979 Budget, specifically, remove the words, "the fund is to be eliminated when compliance is established";
5) Extend the provisional certification waiver period because of the lapse in time involved in the return of reimbursements to Indian Health Service for correcting deficiencies related to staff, physical plant and/or equipment;
6) Enforce regulations related to Medicaid agencies' non-compliance so that eligible Indians residing in the States of Montana and North Dakota, in particular, are not denied their rights to use their Medicaid entitlements in qualified Indian Health Service facilities.
7) Permit Indian Health Service to use federally-derived, quantitative standards for determining staffing deficiencies to supplement general survey findings of the Bureau of Quality Assurance, HEW, and/or those of the Joint Commission on Accreditation of Hospitals so reimbursements to Indian Health Service may be used to address specific staffing deficiencies; and further, permit Indian Health Service to use dollars collected for staff

up to the number of positions the reimbursements will support, taking into consideration other deficiencies, such as those related to a physical plant or equipment;

8) Provide authority to allow IHS to pay Medicaid "spend-down" and mandate states to disregard as income IHS direct care and indirect care—known as contract medical care—in determining and maintaining eligibility for the Medicaid program;

AND BE IT FURTHER RESOLVED, that the Governors of the States of Montana and North Dakota be requested to expedite implementation of Title IV by immediately funding the respective state's Medicaid agency for administrative costs until such time other means for covering such costs are found and, that Tribal governing bodies be urged to seek training programs provided by HEW Regional Offices to assure greater understanding of and participation by all Indians in Social Security Act programs, including Medicare and Medicaid;

BE IT FURTHER RESOLVED that the Director of Indian Health Service be requested to first, where practical, use Medicare and Medicaid reimbursements to help facilities attain compliance followed by use of funds to help other facilities maintain compliance, giving priority in both situations to facilities in areas that collected the funds.

Certification

The above Conference Resolution No. 78-18, having been duly introduced at the plenary session of the Second National Indian Conference on Aging on August 18, 1978, in Billings, Montana, was adopted by unanimous vote, indicating full support of its content.

/Walter L Moffett

Walter Moffett
Chairman
Resolutions Committee

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CONFERENCE RESOLUTION NO. 78-19

WHEREAS, the 96th Congress has recognized the urgent needs of American Indian and Alaskan Native elders to receive all benefits under the Older Americans Act (OAA) to which they are entitled by including in the 1978 Amendments passed by both Houses of Congress provisions for direct grants to Indian tribes, and

WHEREAS, the National Indian Council on Aging acknowledges this action by the Congress as a re-affirmation of its commitment to support Indian Self-Determination by making it possible for Tribal Governments to administer services to their aging constituencies based on locally-determined needs, and

WHEREAS, the National Indian Council on Aging acknowledges this action by the Congress as a re-affirmation of its commitment to support Indian Self-Determination by making it possible for Tribal Governments to administer services to their aging constituencies based on locally-determined needs, and

WHEREAS, the National Indian Council on Aging recognizes that the provisions in the 1978 OAA Amendments addressing Indian needs cannot become reality unless the Congress follows through by authorizing the appropriations required to carry out the intent expressed in Senate Bill 2850, which includes the levels of funding required.

NOW, THEREFORE, BE IT RESOLVED that the American Indian and Alaskan Native elders assembled at this Second National Indian Conference on Aging urge the Congress of the United States to enact the 1978 Older Americans Act Amendments including the provisions addressing Indian needs as reflected in S. 2850 and including full provision of the required funding levels of $25 million for FY-1979 and $30 million for FY-1980 for the implementation of Title VI, and

BE IT FURTHER RESOLVED that the working relationship and coordination between the National Indian Council on Aging, the Administration on Aging, and other

federal service provider agencies be reinforced and expanded by providing to the Administration on Aging the required authority and funding to employ the staff with expertise in service to the national Indian aging community which is required to implement the provisions of Title VI of S. 2850.

Certification

The above Conference Resolution No. 78-19, having been duly introduced at the plenary session of the Second National Indian Conference on Aging on August 18, 1978, in Billings, Montana, was adopted by unanimous vote, indicating full support of its content.

Walter Moffett
Chairman
Resolutions Committee

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CONFERENCE RESOLUTION NO. 78-20

WHEREAS, The Navajo Nation Council on Aging requests the support of the Second National Indian Conference on Aging in the request for additional facilities and services to the elderly of the Navajo Nation,

WHEREAS,

1. There are 14,000 elderly people within the Navajo Nation who are spread over 25,000 square miles of rugged terrain;
2. Ninety percent (90%) of the elderly of the Navajo Nation live below the federally-designated poverty level;
3. New hospital facilities must be constructed as well as the expansion of existing facilities to provide the necessary care and services required by the elderly who generally suffer deplorable health conditions in comparison to other elderly people in this country;
4. A rapidly increasing number of elderly are being placed in off-reservation extended care facilities far from families and home. There is only one facility on the reservation with virtually no home health care services available. Removal of the elderly person from their homes causes severe emotional hardship.
5. Due to an acute lack of transportation there is a severe hardship placed on the elderly to acquire medical and social services, purchase food, haul water or any other necessity that would assure a normal, healthy life.
6. The vast majority of Navajo elderly are suffering from malnutrition due to low income, inaccessability to retail stores, poor diet, and most recently, complete stock reduction in the Navajo/Hopi disputed area indicating a dire need for increased nutritional services through Senior Centers, home-delivered meals to reach the various remote areas outside the more accessible agency communities;
7. Low cost individual housing, group homes and shelter homes, near senior centers or other service facilities must be constructed to meet the social, physical and cultural needs of the elderly as many are unable to maintain their living conditions in rural areas due to lack of family support, poor health and extreme hardships placed upon them due to their remoteness.
8. At least 80% of the elderly do not even have running water or electricity which is taken for granted by the majority of the United States. Sanitation conditions are limited to availability of water and preservation of fresh foods is nearly impossible.

NOW, THEREFORE, BE IT RESOLVED THAT, the Representative Delegation of the Navajo Nation Council on Aging requests the support of the Second National Indian Conference on Aging in the efforts made to provide the basic human

necessities of health, mobility, physical and mental well-being to the elderly of the Navajo Nation.

Certification

The above Conference Resolution No. 78-20, having been duly introduced at the plenary session of the Second National Indian Conference on Aging on August 18, 1978, in Billings, Montana, was adopted by unanimous vote indicating full support of its content.

Walter Moffett
Chairman
Resolutions Committee

NATIONAL INDIAN CONFERENCE ON AGING

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NATIONAL INDIAN COUNCIL ON AGING, INC.

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CONFERENCE RESOLUTION NO. 78-21

WHEREAS, the Navajo Foster Grandparent Program, under the sponsorship of the Office of Navajo Economic Opportunity, Navajo Nation, Fort Defiance, Arizona, and funded by ACTION, the Federal Volunteer Agency (established in Title II, Part B, Sec. 211 (a) of Public Law 93-113, 45 CFR 1208, has 118 elderly volunteers serving at forty (40) locations throughout the Navajo Nation;

WHEREAS, Public Law 93-113, Title II, The National Older American Volunteer Programs, states in Part C, Section 223 (a) the following:

"The Director shall take appropriate steps to insure that special efforts are made to recruit, select and assign qualified individuals sixty years and older from minority groups to serve as volunteers under this title."

WHEREAS, Public Law 93-113, Title II, The National Older American Volunteer Programs, further states in Part C, Section 404 (b) the following:

"All support, including transportation provided to volunteers under this Act, shall be furnished at the lowest possible costs consistent with effective operation of volunteer programs."

WHEREAS, The Navajo Foster Grandparent volunteers are all certified to be under the National Poverty Guidelines as set forth in section 625 of the Economic Opportunity Act of 1964, as amended by Public Law 92-424 (42 U.S.C. 2971d), and by ACTION, as established effective July 5, 1978.

WHEREAS, The stipend benefit provided by the ACTION Agency to Foster Grandparent volunteers has remained at $1.60 for the past ten (10) years while the general physical well being and standard of life as related to health needs for these volunteers has not been met, because of inadequate services on the Navajo Nation.

NOW, THEREFORE, BE IT RESOLVED, the Navajo Foster Grandparents Volunteers and and the Office of Navajo Economic Opportunity respectfully request that consideration be given to the following recommendations:

A) 1) Considering Public Law 93-113, Title II, The National Older American Volunteer Programs states that support to volunteers be furnished at the lowest possible cost, but **consistent with effective operations** of volunteer programs and 2) considering that the cost of living has increased annually, and will continue to increase for most households, we recommend that the Foster Grandparent **stipend rate be adjusted from $1.60 to $2.00 per hour**, in conformance with ACTION's stated desire for consistent and effective

operations, as well as humane responses to economic needs of the Foster Grandparent Volunteers.

B) As stated in Public Law 93-113, Title II, The National Older American Volunteer Programs, Part C, Section 223, the Director is obligated by law to insure special efforts to recruit, select, and assign qualified minority elderly, sixty years and older. Navajo Foster Grandparents Program recommends that considering the culture and tradition of Native Americans where many elderly are out of the regular work force by fifty (50) years of age and where the life expectancy is far below the National average that the **age requirement be lowered to 55 years of age for applicants.**

BE IT FURTHER RESOLVED, that the Navajo Foster Grandparent Program and Office of Navajo Economic Opportunity recommends ACTION Volunteer Agency the National Indian Council on Aging, and the Senate Special Committee on Aging, the attached position statement submitted by the Foster Grandparents themselves (Original was submitted November 12, 1977 to Senator Dennis DeConcini at the Senate Sub-Committee Hearings on Problems of Indian Elderly held in Phoenix, Arizona.)

B) The Navajo Foster Grandparent Program and Office of Navajo Economic Opportunity recommends that ACTION Volunteer Agency extend involvement of their meaningful programs, of which Foster Grandparents is a part, to other Native American tribes who could benefit immensely from the goals and concepts of their programs.

Certification

The above Conference Resolution No. 78-21, having been duly introduced at the plenary session of the Second National Indian Conference on Aging on August 18, 1978, in Billings, Montana, was adopted by unanimous vote, indicating full support of its content.

Walter Moffett
Chairman
Resolutions Committee

Response to Conference Resolutions from U.S. Department of Labor Employment and Training Administration

Thank you for your letter dated February 14, 1979, to Secretary Marshall which I have been asked to answer. I am the Director of the Office of National Programs, Employment and Training Administration. National programs for Native Americans under Section 302 of the Comprehensive Employment and Training Act (CETA) and the Senior Community Services Employment Program (SCSEP) under the Older Americans Act are administered by components of the Office of National Programs.

Enclosed with your letter are three resolutions adopted by the Second National Indian Conference on Aging. My comments on these resolutions follow:

Conference Resolution No. 78-2: This resolution asks that the regulations be changed to allow the use of county population figures in determining the proper minority hiring levels under SCSEP. The resolution notes that the census is taken every decade resulting in inaccurate population figures for use in the program. I do not question the points made in the resolution. However, if State figures are inaccurate because of the lapse of time between each census, the county figures are similarly inaccurate. Using county data in place of State data will not improve the quality or accuracy of the data since State totals are merely the sum of county and census tract figures. Moreover, Section 502(b)(1)(m) of the Older Americans Act states: "No payment shall be made by the Secretary toward the cost of any project established or administered by any such organization or agency unless he determines that such project. . . will assure that, to the extent feasible, such project will serve the needs of minority, Indian and limited English-speaking eligible individuals in proportion to their numbers in the State...."

Conference Resolution 78-5: This resolution recommends that the State be required to comply with CETA regulations insuring that the percentage of slots allocated to the elderly be fully utilized.

Programs for middle-aged and older workers are clearly specified in Section 308 of the CETA reauthorization of 1978. I have enclosed a copy of Section 308 for your information. CETA regulations require State and local prime sponsors of CETA programs to provide for services to older workers in direct proportion to their percentage of the population. Annual comprehensive employment and training plans submitted by State and local prime sponsors are reviewed by the Department of Labor to insure that older workers receive their fair share of the CETA dollar. State and local prime sponsors are required to adjust their plans accordingly if they are deficient in their planned service to older workers.

Conference Resolution No. 78-17: This resolution recommends that appropriations under CETA Title VI for Native Americans be maintained at the present level for elderly Native American Indian residents of various cities.

Elderly Native Americans are served through CETA programs funded under Titles II, III and VI by both Native American grantees and State and local government prime sponsors. The total CETA appropriation requested in the Fiscal Year 1980 budget for these programs which service the elderly and other eligible citizens through public service jobs is $4,590,500,000 as compared to $4,431,030,000 in Fiscal Year 1979.

I appreciate your interest in employment and training programs for older workers and this opportunity to respond to your organization's resolutions. Please let me know if I can be of further assistance.

Sincerely,

/s/ LAMOND GODWIN
Administrator
Office of National Programs

"PROJECTS FOR MIDDLE-AGED AND OLDER WORKERS

"SEC. 308. (a) The Secretary shall—

"(1) develop and establish employment and training policies and programs for middle-aged and older workers which will reflect appropriate consideration of these workers' importance in the labor force and lead to a more equitable share of employment and training resources for middle-aged and older workers;

Employment and training policies.
29 USC 878.

"(2) develop and establish programs to facilitate the transition of workers over 55 years of age from one occupation to another within the labor force and to facilitate the transition of such workers from non-participation to participation in the labor force including work experience, vocational education, public service employment, on-the-job training, occupational upgrading, and job search and placement, and technical assistance to employers for establishing flexi-time, job sharing, and other innovative arrangements suited to the needs of older workers;

"(3) conduct research on the relationships between age and employment and insure that the findings of such research are widely disseminated in order to assist employers in both the public and private sectors better understand and utilize the capabilities of middle-aged and older workers; and

Research.

"(4) develop and establish programs to develop methods designed to assure increased labor force participation by older workers who are able and willing to work but who have been unable to secure employment or who have been discouraged from seeking employment.

"(b) In carrying out the provisions of subsection (a) the Secretary shall provide for appropriate arrangements to be made with prime sponsors, members of the business community (including small business), labor organizations, local educational agencies, and community-based organizations as defined in section 3. Such arrangements may include, but need not be limited to—

Ante, p. 1912.

"(1) an analysis of the local labor force on the basis of such factors as age, educational background, income, race, and sex, focusing particularly on comparative rates of labor force participation and of unemployment and underemployment among the various demographic groups studied;

"(2) an assessment of each participant's skills and work experience for purposes of formulating realistic second career objectives, including formal vocational testing instruments supplemented by such functional assessment methods and techniques to detect those skills and abilities of a participant as may be related to desired second career and occupational upgrading objectives;

"(3) second career and occupational upgrading counseling by individuals knowledgeable about the employment and training needs of middle-aged and older workers;

Counseling.

"(4) the establishment of second career objectives which will—

Second career objectives.

"(A) provide reasonable assurances to the participant that public and private sector demand exists for the skills developed in the second careers program; and

"(B) enable the participant to compete successfully in the job market; and

"(5) establishment of formal second careers training agreements, between participants and program sponsors, which—

"(A) set forth the career objectives of the participants and the steps required of each participant and prime sponsor to achieve these objectives;

"(B) will remain in force until its terms are fulfilled, or renegotiated or terminated according to such procedures as shall be prescribed by the Secretary; and

"(C) may be renegotiated or terminated, at any time, by the participant, or by the program sponsor for good cause.

(c) The Secretary is hereby authorized to pay program sponsors reasonable training costs to participants in second careers programs to the extent necessary to achieve the objectives of such programs in accordance with regulations prescribed by the Secretary, but in no case shall such payment exceed the permissible maximum under section 122(i)(1). Such costs may include reasonable tuition for participants engaged in technical or other institutional training and payments to program sponsors providing on-the-job training, provided that such payments are based on the actual number of hours of such training given to the second careers program participant. The Secretary is authorized to pay for equipment, materials, and such other costs necessary for a participant to achieve the objectives of his second careers program.

Payment, regulations.

Ante, p. 1938.

"(d) Programs assisted under this section may provide for participation in employment and training programs on a part-time or flexible-time basis.

Part- or flexible-time programs.

"(e) Participants in programs authorized under this section shall be individuals over the age of 55 who are unemployed, underemployed, or economically disadvantaged, who have a family income (exclusive of any income received under a Federal or State welfare or unemployment program) which is not in excess of 125 percent of the poverty level established by the Director of the Office of Management and Budget.

Eligibility.

"(f) For the purposes of carrying out this section, the Secretary shall reserve from funds available for this title not more than 5 percent of the amount available for this title.

Allocation of funds.

"(g) No provision of this section shall be construed as intending any diminution of the employment and training opportunities available to workers over 55 years of age under titles II, VI, and VII of this Act."

Ante, p. 1950; Post, pp. 2005, 2010.

Response to Conference Resolutions from Assistant Secretary—Indian Affairs United States Department of the Interior

In response to your letter of February 14, I have had my staff review the Conference Resolutions. We would like to make the following remarks about the material which you have presented:

Conference Resolution 78-4: The issue of intermediate nursing home care was only a problem in the state of Arizona. This problem was resolved in early October, 1978.

Conference Resolution 78-6: Any out-of-home care is most appropriate to the needs of the patient in the nearest proximity to the patient's home environment, and approximating that environment when possible. This would apply especially to Indian senior citizens who have spent all, or the majority of their life on or near the reservation in a culture quite different than most off-reservation cultures. However, it is the economic feasibility of developing nursing homes, as in this case, an extended skilled care facility on the reservation, that is often difficult to overcome.

Conference Resolution 78-11: Since the publication of the Financial Assistance and Social Services Program regulations on February 2, 1977, non-Indian members of an Indian household are not eligible for general assistance.

Conference Resolution 78-14: As your Resolution indicates Burial Assistance is a program in the Bureau of Indian Affairs. No one who meets the eligibility requirements, should be denied.

Conference Resolution 78-20: The needs of the elderly people within the Navajo Nation are clearly enumerated in this resolution. We would encourage the Navajo Nation in its efforts to provide for the basic human necessities of health, mobility, and physical and mental well-being for their elderly, but would suggest that they move one step further in their efforts and develop an action plan for meeting those needs, which includes specific activities, and potential funding sources. It is only when these plans are developed that any "real" support can be given the Navajos.

I appreciate this opportunity to review this material, and offer comments and suggestions.

Sincerely,

/s/ Forrest J. Gerard
Assistant Secretary—Indian Affairs

CIVIL AERONAUTICS BOARD
WASHINGTON, D.C. 20428

IN REPLY REFER TO: B-66

May 24, 1979

Mr. Walter Moffett
Chairman, Resolutions Committee
National Indian Council on Aging, Inc.
P.O. Box 2088
Albuquerque, New Mexico 87103

Dear Mr. Moffett:

We have received the copy of your Conference Resolution No. 78-12, requesting that senior citizens, 65 years or older traveling on reduced fares should not have to travel on a standby basis.

Public Law 95-163, passed by the Congress on November 9, 1977, allowed the airlines to offer reduced fares to senior citizens--but only on a space-available basis. However, most carriers offering these fares now permit reservations to be made one day before departure. The Board permitted them to do so because it believed that such limited reservation capability is not inconsistent with the space-available requirement of the law.

We would add, however, that there are other discount fares available now to all persons that senior citizens might find more attractive, although they are subject to certain restrictions. It is, therefore suggested that passengers contact, in advance, the individual airlines or travel agent to determine whether a lower fare may meet their travel needs.

We hope this information will be helpful.

Sincerely,

Randall D Bennett

Randall D. Bennett, Chief
Domestic Passenger Fares
Division
Bureau of Domestic Aviation

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U.S. House of Representatives
Select Committee on Aging
Washington, D.C. 20515

TELEPHONE: (202) 225-3375

April 12, 1979

Mr. Robyn J. York
National Indian Conference on Aging
Post Office Box 2088
Albuquerque, New Mexico 87103

Dear Mr. York:

You were very kind to send me copies of the Resolutions adopted by the National Conference on Aging. I found them pertinent and informative.

I am concerned with the rights and entitlements of all older Americans; and have always been particularly interested in the plight of the elderly native Americans. The resolutions certainly pointed up areas of unmet needs. The Committee on Aging will pledge its best efforts toward improving the physical and social well-being of the Indian elderly.

Thank you again for sending me the resolutions adopted by your Conference. Be assured that I will be supportive of your efforts, particularly with regard to funding for title VI of the Older Americans Act.

With warm regards, and

Believe me,

Always sincerely,

Claude Pepper

Claude Pepper
Chairman

CP/eha

Evaluation of Conference

The NICOA General Council met on the morning of August 18, 1978, to evaluate the conference just completed. Recommendations for future conferences were referred to the NICOA Conference Planning Committee.

In addition, the White Cloud Center for American Indian and Alaskan Native Mental Health Research and Development, of the University of Oregon, distributed questionnaires to conference participants for the evaluation of workshops. The results of these evaluations are presented in the accompanying table.

Henry Beaver, oldest Indian man participating in the Conference, was honored with a gift of a Pendleton robe.

WORKSHOP EVALUATION—AGING CONFERENCE
BILLINGS, MONTANA
AUGUST, 1978

QUESTIONS	NUTRITIONAL CONCERNS				HEALTH EDUCATION				COMMUNITY RESOURCES				ALTERNATIVE TO INSTITUTIONAL CARE				TRAINING OF HOME CARE				INDIAN MEDICINE AGING CONCEPT				TRIBAL SPECIFIC HEALTH PLAN PL94-437				LONG TERM CARE				MEDICARE & MEDICAID			
	No. responded	% Yes	% No	% No comment	No. responded	% Yes	% No	% No comment	No. responded	% Yes	% No	% No comment	No. responded	% Yes	% No	% No comment	No. responded	% Yes	% No	% No comment	No. responded	% Yes	% No	% No comment	No. responded	% Yes	% No	% No comment	No. responded	% Yes	% No	% No comment	No. responded	% Yes	% No	% No comment
1. Were the ideas presented and discussed of concern to you?	40	95	0	5	18	100	0	0	15	93	0	7	7	86	14	0	5	100	0	0	13	100	0	0	14	79	14	7	33	82	18	0	18	100	0	0
2. Did the workshop organization allow you to discuss your ideas and concerns?	40	80	12½	7	18	67	28	5	15	93	0	7	7	72	14	14	5	100	0	0	13	62	23	15	14	86	14	0	33	61	36	3	18	100	0	0
3. Did the activities of this workshop increase your awareness considerably?	40	77½	17½	5	18	78	17	5	15	100	0	0	7	86	14	0	5	100	0	0	13	100	0	0	14	86	14	0	33	100	0	0	18	100	0	0
4. Do you think the small group discussion was worthwhile?	40	90	5	5	18	72	0	28	15	93	0	7	7	100	0	0	5	100	0	0	13	92	8	0	14	100	0	0	33	88	6	6	18	100	0	0
5. When the panelists answered questions from the audience, did you feel they were direct in their responses?	40	87½	5	7½	18	72	17	11	15	87	0	13	7	86	14	0	5	100	0	0	13	92	0	8	14	86	7	7	33	82	0	18	18	100	0	0
6. Do you think what you learned will be useful to you?	40	95	5	0	18	94	6	0	15	100	0	0	7	100	0	0	5	100	0	0	13	100	0	0	14	86	7	7	33	94	6	0	18	100	0	0
7. Did you feel the panelists knew what they were talking about?	40	80	15	5	18	100	0	0	15	100	0	0	7	100	0	0	5	100	0	0	13	92	0	8	14	93	7	0	33	91	6	3	18	100	0	0
8. Did the presentation move along?	40	87½	10	2½	18	89	5½	5½	15	100	0	0	7	86	14	0	5	60	0	40	13	77	0	23	14	86	0	14	33	94	3	3	18	100	0	0
9. Did your group have enough time for discussion?	40	70	25	5	18	50	50	0	15	73	20	7	7	71	29	0	5	40	20	40	13	31	61	8	14	43	43	14	33	24	76	0	18	89	11	0
10. Is there anything else about the small groups that you would like to comment on? Please write in the space below.	1. Group was too large. 2. Could not hear the questions that were asked. 3. The smaller group is where the people can feel more comfortable to speak their mind freely. 4. Need to stick to subject. 5. More time. 6. The commodities program explained further. 7. More on food stamp litigation errors.				1. Moderator did an excellent job of coordinating program. Good presentation. 2. Wish session was longer. 3. We didn't have small group. Session too short.				1. This was very good.				1. Too bashful to speak up. 2. I would like to recommend that NICA ask PHS and HUD to set aside monies for nursing homes. 3. Very interesting and I have picked up on a few new ideas.				1. I would like to know more about CHR's role in home care for the elderly. 2. Very helpful, very interesting.				1. Excellent speakers. 2. Enjoyable and answers about what the medicine man is and what he does. 3. Recommend open group discussion, no panelists. Different tribes have their way of Native healers & be very interesting to discuss among the members.				1. Before money grants are issued it be specifically stated, tribal council members' children all not be appointed high key jobs unless they have the education. 2. Coordination of different federal agencies for one tribal project. 3. More time should be allowed between workshops so people could get there on time. 4. No exhibits in hallways by place of workshop—it distracts people from workshop.				1. Do you have any pamphlets on guidelines for each position? 2. Can any reservation participate in this program? 3. More time. 4. Excellent film. 5. Good. 6. Not enough time. 7. Too short of time.				1. Panelists were very helpful — very knowledgable; it's always much easier. 2. Please send copies of resolution to members who signed up on ledger.			

Conference Agenda

AGENDA
Second National Indian Conference On Aging
TUESDAY, AUGUST 15, 1978

1:00 P.M. - 9:00 P.M.	Registration	Lobbies of Montana Convention Center & Eastern Montana College
3:00 P.M.	Orientation for Moderators	Holiday Inn-West — Holidome Center
4:00 P.M.	Orientation for all Volunteer Staff Workers	Holiday Inn-West — Holidome Center
5:00 P.M. - 9:00 P.M.	Exhibit Set Up	Ramada Inn

WEDNESDAY, AUGUST 16, 1978

8:30 A.M.	Daily Registration	Lobbies of Montana Convention Center & Eastern Montana College
	Exhibit Opening	Ramada Inn
9:00 A.M.	GENERAL ASSEMBLY	Montana Convention Center
	Call to Order	George Effman, *Chairman*, National Indian Council on Aging
	Invocation	Earl Old Person, *Member*, Blackfeet Tribal Business Council
	Opening Remarks	George Effman, *Chairman*, NICOA Sophie D. Thompson, *Conference Chairperson*, NICOA
	Welcoming Introductions	Madeline Colliflower, *Board Member*, NICOA — Billings Area
	Welcome from Host Tribes	Allen Rowland, *President*, Northern Cheyenne Tribal Council John Allen, *President*, Fort Belknap Community Council
	State of Montana	The Honorable Thomas L. Judge, *Governor* of Montana
	Billings, Montana	The Honorable William Fox, *Mayor* of Billings
	Billings Area — Indian Health Board	Ada White *Chairperson*
	Billings Area — Indian Health Service	James Smith, *Area Director*
	Billings Area — Bureau of Indian Affairs	James A. Canon, *Area Director*
	Eastern Montana College Billings, Montana	John Van de Wetering, Ph.D., *President*
	INTRODUCTION OF SPEAKERS	George Effman, *Chairman*, National Indian Council on Aging
	U.S. Department of the Interior	
	U.S. Department of Health, Education and Welfare, Indian Health Service	Emery Johnson, M.D., *Assistant Surgeon General; Director, Indian Health Service*
	U.S. Department of Health, Education and Welfare	Jerry Bathke, *Special Assistant to the Commissioner*, Administration for Native Americans
	Historical Perspective — The Indian Effort in the Field of Aging	Wendell Chino, *Honorary Chairman*, NICOA and *President*, Mescalero Apache Tribe
	Progress Report	Juana Lyon, *Executive Director* and Larry Curley, *Liaison Specialist*, National Indian Council on Aging

Agenda - continued

WEDNESDAY, AUGUST 16, 1978

	Introduction of IHS Technical Background Papers	Emery Johnson, M.D., *Assistant Surgeon General; Director,* Indian Health Service
12:00 Noon	LUNCH RECESS	
1:30 P.M.	Reconvene	George Effman, *Chairman*
	Legislative Perspective	Cynthia Hilton, *Minority Staff Director,* Sub-Committee on Health and Long Term Care of the House Select Committee on Aging
		Panel Members
	CONTINUUM OF CARE	Janice Kekahbah, R.N., M.A., *Executive Director,* American Indian Nurses Association
3:00 P.M.	Special Break	Navajo Nation Council on Aging
3:15 P.M.	PHYSICAL HEALTH PROBLEMS OF ELDERLY INDIANS	Gerald Ignace, M.D., *Chairman,* Board of Directors, Assn. of American Indian Physicians
	MENTAL HEALTH PROBLEMS OF ELDERLY INDIANS	Everett R. Rhoades, M.D., University of Oklahoma and Veterans Administration
	THE ENVIRONMENT OF ELDERLY INDIANS	Reaves Nahwooksy, *Director,* Indian Administration Program, University of New Mexico
	SAFETY AND ELDERLY INDIANS	Oren Tonemah, *Executive Director,* National American Indian Safety Council, Inc.
5:00 P.M.	Daily Registration Closes	
6:00 P.M. - 9:00 P.M.	BUFFALO BARBECUE	Eastern Montana College Campus Co-Hosts: Northern Cheyenne Tribe and NICOA

THURSDAY, AUGUST 17, 1978

8:30 A.M.	Daily Registration Opens	Montana Convention Center
	Exhibit Opening	Ramada Inn
	GENERAL ASSEMBLY	Montana Convention Center
	Call to Order	George Effman, *Chairman,* NICOA
	Invocation	Walter Moffett, *Treasurer,* NICOA & *Member,* Federal Council on Aging
	Welcome from Host Tribes	Don Boggs, *Chairman,* Blackfeet Tribal Business Council
		Forrest Horn, *Chairman,* Crow Tribal Council
		Norman Hollow, *Chairman,* Ft. Peck Tribal Executive Council Board
	Task Panel Report — "A GOOD DAY TO LIVE FOR ONE MILLION INDIANS"	Phyllis Old Dog Cross, *Special Assistant to* LaDonna Harris, *President,* Americans for Indian Opportunity
	The Role of the National Indian Health Board	Howard E. Tommie, *Chairman,* National Indian Health Board and *Chairman,* Seminole Tribal Council
	Overview of Workshops	John Carlile, *Vice-Chairman,* National Indian Council on Aging and Aging Program Director of the Cherokee Nation of Oklahoma
9:50 - 10:40 A.M.	Workshops	(See schedules and locations
10:50 - 11:40 A.M.	Workshops	on following page)
12:00 Noon	LUNCH RECESS	

Agenda - continued

THURSDAY, AUGUST 17, 1978

1:30 P.M. - 3:25 P.M.	Workshops (Continued)	
3:30 P.M. - 4:40 P.M.	Workshops	
5:00 P.M.	Deadline for Submission of Resolutions	Suite 106 — Conference Office Holiday Inn-West
	Daily Registration Closes	
7:00 P.M. - 9:00 P.M.	Awards and Recognition Banquet	Montana Convention Center
	Master of Ceremonies	Jay Harwood, *Area Director*, IHS — Albuquerque Area
	Entertainment — Traditional Style Show	Hostesses: Madeline Colliflower NICOA — Billings Area Doris Limberhand, Billings Area Indian Health Board
		Narrator, Karen Fenton, *Human Resource Specialist*, BIA
	Guest Speakers	Robert Benedict, *Commissioner on Aging*
		Arthur S. Flemming, Ph.D., *Chairman*, U.S. Commission on Civil Rights
	Presentation of Awards	Wendell Chino, *Hon. Chairman* George Effman, *Chairman* Sophie D. Thompson, *Conf. Chr.*

FRIDAY, AUGUST 18, 1978

8:00 A.M.	Daily Registration Opens	Montana Convention Center
	Exhibit Opening	Ramada Inn
8:30 A.M.	GENERAL ASSEMBLY	Montana Convention Center
	Call to Order	George Effman, *Chairman*
	Invocation	John Wooden Legs, *Spiritual Leader and Member*, Northern Cheyenne Tribal Council
	Welcome from Host Tribes	John Windy Boy, *Chairman*, Chippewa Cree Business Council
		Tom Swaney, *Chairman*, Flathead Tribal Council
9:00 - 10:30 A.M.	Senate Special Committee on Aging — Information Exchange on the Older Americans Act	Letitia Chambers, Ph.D., *Minority Staff Director*, Jeffrey Lewis, *Professional Staff* Philip S. Corwin, *Professional Staff*
10:30 A.M.	Special Break	Navajo Nation Council on Aging
10:45 A.M.	Report from Workshop Moderators-Recommendations	
12:00 Noon	LUNCH RECESS	
1:30 P.M.	Reconvene	George Effman, *Chairman*
	Resolutions Presentation	Walter Moffett, *Chairman*, NICOA Resolutions Committee
	Report from White Cloud Center	Audra Pambrun, R.N., D.Sc., *Program Analyst*
4:00 P.M.	Summary and Projections for the Future	George Effman, *Chairman*, National Indian Council on Aging
	Benediction	Rev. Robert Pinezaddleby, *Member*, NICOA — Anadarko Area
	Adjournment	

Conference Speeches

Welcoming Remarks of Governor Thomas L. Judge at the National Indian Conference on Aging, Montana Convention Center, Billings, Montana, Wednesday, August 16, 1978, 9:00 a.m.

It is a pleasure to welcome, on behalf of the State of Montana, the participants in this Second National Indian Conference on Aging. I congratulate the Montana Northern Cheyenne Tribe for participating in this Conference.

The problems of aging people of this nation—problems of reduced income, increased health problems, loneliness, isolation—are magnified for aging Native Americans. A statement, written in 1975 by the Administration on Aging and the Office of Native American Programs, spells out just how magnified those problems are. The statement, which reflects conditions that have not changed in the past three years, reads:

"When measured by incidence of poverty, illness and privation, American Indians have needs far out of proportion to their numbers. Whatever the living conditions of American Indians in general, the living conditions of the elderly are even worse. Rarely reaching "old age" as measured by non-Indian society, living on isolated reservations, lacking in mobility, faced with major nutritional problems and having virtually no income, the elderly American Indian often finds daily living a struggle for survival. No other group of older Americans is faced with so stark a reality in their old age as is the elderly American Indian."

Social, economic and health problems of aging Indians are, indeed, especially severe when compared to other older Americans. The high incidence of early death, disease, discrimination and poverty is an all too common fact of life for these unique older people. In Montana's state plan for the elderly, authority was sought and granted under the Older Americans Act to consider Indian Americans "old" at age 45, in recognition of the social facts of these people's life condition.

It is starkly apparent to me that the first great problem of the Indian elderly is that old age starts at age 45—a time which, in non-Indian society, is considered to be "the prime of life." Therefore, it would seem that a realistic approach to the problems of Indian aging would have to include Indian life-expectancy, Indian living conditions in general.

The roots of the problems for Montana's Indian elderly are different from those of non-Indian senior citizens. A majority of **all** aging people are coping with the economic consequences of living on fixed, reduced incomes that do not compensate for inflated costs of living; but for elderly Indians economic conditions are extremely severe, with annual incomes of less than $3,000. **All** elderly people are vulnerable to increasing health problems, but for American Indians health services are either not available at all or are inaccessible because of inadequate transportation.

But perhaps the most unique of the differences between aging Indians and the non-Indian elderly has no comparative. While many older people suffer the corrosive effects of isolation and loneliness, that problem for the Indian elderly comes from a different base and has, consequently, a far more severe effect. In traditional tribal society, the elderly were a needed and highly respected people. The widsom and experiences that were the product of having lived a long time were of value to the rest of the Indian community—and, therefore, the aging Indian was not merely "elderly" but was an "elder," a person of substance and value, a person with inviolate dignity, a person held in great respect. Councils of elders were the active centers of tribal decision-making, holding a place of prominence in governmental and political affairs. It was through the elders that the culture of the people was transmitted down the generations. Lacking a written tradition, the entire history, language, art, and value system of the people were passed on to younger generations by the elderly through the oral tradition.

That respected status no longer exists for the aging Indian. Instead of being an integral part of the Indian lifestyle, today's aging Indian is an isolated part of a broken family structure. Instead of being in line to be a valued elder, today's aging Indian is in line for welfare assistance. Instead of being valued by the people, today's Indian elderly are burdens on the limited resources of a stressed people. Instead of living with status in a familiar world, today's aging Indians are faced with being poor and neglected on the reservation or uprooted to an urban environment to be poor and neglected in a foreign world.

We know, to a great extent, what the problems of the aging Indian are. We know, to a great extent, why those problems exist—what the causes are. Now we must discover how to solve those problems and, most importantly, we must be determined that those solutions will be put into effect.

I have hopes that this Conference will produce real solutions to real problems. Throughout the three days of this Conference you will address physical and

mental health problems of elderly Indians; you will be presented with an overview on alternatives for planning a continuum of various levels of care for elderly persons; you will hear a presentation on the ways safety and accidents relate to the Indian elderly, and what concrete actions can be taken to change adverse effects of those factors; and you will address the physical, social and spiritual environment of the Indian elderly and how various elements of that environment influence the aging. A series of 17 workshops will treat a wide range of subjects of direct effect on elderly Indians.

It is my sincere hope that these various explorations of the concerns and problems of the aging Indian will be fruitful, and that the Circle of Life will be brightened and made whole again for these people who should be "elder" and not merely "elderly."

Thank you.

Excerpts of Speech of Dr. Emery Johnson, Director, Indian Health Service

of August 16, 1978

It's really great to be back in Montana! I'm back in Montana, and it gives us all from other parts of the country a chance to see the group of tribes I've worked with a number of years who, I think, have gotten their act together pretty well. A lot of positive things have come out of Montana.

We are bringing greetings from the health side of HEW: Dr. Julius Richmond, the Assistant Secretary for Health to the Surgeon General of the United States, Depaartment of Health, Education and Welfare, and Dr. George Lythcott, Administrator of the Health Services Administration. Dr. Lythcott had planned to be here and was looking forward to it, but he is discovering in his brief year in Washington as administrator, he does not always have control over his own time. Washington goes by its own speed and cycles, just as Mr. Gerard finds himself before the Senate Committee this morning, not of his choosing. Dr. Lythcott's schedule has him wrapped up and he's unable to be here. So I am bringing you greetings from Dr. Richmond and Dr. Lythcott.

The real guts of this conference is not the speeches, but the workshops coming up with reality-based assessment of problems. Looking at the options to solutions and then getting ourselves together and pushing for action on a limited number of durable things.

We got the message across this morning to those who are working in the area of legislation, for example in the Older Americans Act passed by both the House and Senate, although in somewhat different form, I understand. A commitment to letting the tribal government handle their own aging programs. I know that Commissioner Benedict is looking forward with great enthusiasm to implementing that part of legislation.

When we come to a conference like this, we have to start out with those basic elements of reality. Try to understand the world we live in, and then do our planning and set our goals and objectives and have some reasonable hope of being successful.

We are seeing in the federal level as we work with the agencies of government and work with Congress, that there is a very well-organized group, apparently well-financed, who in the name of equal rights are out to trample on Indian rights. All right, that is real, you know it. Hopefully, knowing this, we can deal with it.

There is a second negative activity going on that has nothing to do whatever with Indians, but it is a reality and we have to face it. It is known as the taxpayers' revolt. You all know what Proposition 13 is. We are seeing cutting back of programs, holding their growth or whatever. That is reality.

This has nothing to do with Indians and it is not related to the anti-Indian backlash. Unfortunately, they are all coming at the same time. We all know what tends to happen under circumstances like that. The groups that have the smallest voice, the least powerful leverage on the government, are the ones whose programs and interest seem to get lost quickly under those circumstances.

I think we have got to face that kind of reality and look at our options, keeping in mind the anti-Indian backlash and the real budget crunch. They won't go away. We have to deal with them. The first thing, it seems to me, is that we simply have to get our acts together. We cannot afford the luxury of commotion that we sometimes create between each other. The white man has for years used that 'divide and conquer' tactic as a mechanism for getting Indian land, Indian water, Indian minerals, setting tribe against tribe, tribes against their friends. We need to clearly try to define for each other what our mutual goals are and how we can, in fact, work in support of legitimate Indian interests.

In the area of planning, find out where you are and where we are. We, means you and me, the health professional staff and the bureau folks or whoever it is that has concern and commitment, willingness to work with us to achieve the goals of Indian people in general, the elderly people specifically. Where are we, what do we need to do, and where do we have to go? Find those things that are critical, things that are absolutely essential to effective programs for elderly people and put our emphasis on that and not scatter out on the horizon.

In my judgment, we must justify additional resources being devoted for Indian programs, elderly programs or any kind of programs, to be able to demonstrate that we are effectively utilizing resources we have. I saw President Carter's Zero Base budgeting which I think is a serious attempt on his part to improve the effectiveness of the decision-making process of management within the federal government.

This will require on our part, good planning, good management and good coordination of resources. In my judgment, there can be coordination of Indian

programs on the reservations through tribal government. There has got to be, in my judgment, a mechanism in tribal government and the institutions that the tribe may set up to carry out its executive functions, strengthening tribal government, an erfectively managed tribal government. I think we have fine leadership in the Indian community. We have responsible leadership and competent leadership. We have dedicated and committed leadership. We have got people who know where they are and who know where they are going. They know how to get things done and without them, in fact, we would be in real trouble. We've got that kind of leadership in the Indian communities. It's leadership that is willing to work within the system, because we are in fact of the American system.

In the Older Americans Act, a provision will allow tribal governments to receive funding directly from the Administration on Aging. A commitment to soundness of tribal government. Recognigion of that as the mechanism. It is, in fact, a commitment of faith in tribal government. This is a commitment on the part of the Congress that tribal government has the responsibility and capability and willingness for health planning on the reservation. The tribal government is the mechanism.

I am the eternal optimist, as most of you know; I believe in the end righteousness will prevail. I think our cause is right. I think we have the capacity to move on the cause in a conference like this. Not speaking of words, but the setting in motion of strategies and actions that are going to be solutions that we are seeking.

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Excerpts of Address by Robert Benedict, Commissioner, Administration on Aging

(Awards and Recognition Banquet, August 17, 1978)

In its very short life, the National Indian Council on Aging has already become a very important, effective and respected voice in shaping national policy.

Dr. Arthur Flemming, who is here tonight, is a man of great vision and sense of compassion. He made it possible in many respects for the Older Americans Act to begin addressing the needs of the Indian community. I am here tonight to reaffirm the commitment of the Administration on Aging to work closely with the National Indian Council on Aging to reaffirm their commitment of their way, review with you and update the statements of assurances which were issued by Dr. Flemming in 1976. The purpose was to assure that equal access to services under the Older Americans Act would be available to you. I want to assure you of my personal commitment to work with the Council to effectively implement the new provisions of the Older Americans Act which we hope will become a reality when Congress completes its work on the Act later this Fall.

As one looks back over the past three or four years, it has marked some very important achievements. Many achievements can be directly attributed to the efforts of the Council. Your conferences and meetings have brought a new sense of understanding to the problems of Indians. It has brought a new sense of purpose within your own Indian communities. It has helped in a very important way to begin shaping national policy related to older Indian people. Your advocacy without question is responsible for the changes in the Older Americans Act which will create a specific and special place in providing services directly to Indian tribes. These are important beginnings. There is an enormous amount of work yet to be done. The efforts of the Council and the thoughtful and appropriate support that Commissioner Flemming has given, laid the foundation upon which the rest of us must build.

We can keep those activities a permanent and responsible part of the Older Americans Act. The new provisions will specifically authorize the Administration on Aging to make direct grants to tribes and tribal organizations. I would like to share with you the policies and principles which I would like to consider as we implement those provisions. First, fundamentally, this provision of the law is one more statement from the Congress and from the federal government that we must learn to understand and respect the full meaning of Indian sovereignty. As we approach the implementation of those provisions of the law that tribes must assume responsibility for services for older people, you share the same responsibilities, the same authorities and the same respect from the Administration on Aging we afford to any of the sister states in their obligations to older citizens. Secondly, as we move toward the implementation of the law, we must share together an open and public process in the development of the regulations and the development of the national plan to carry out those provisions of the law. We must share the responsibilities.

Headtable at Awards Banquet — l to r: John Carlile, NICOA Vice-Chairman (Muskogee Area); Dr. Arthur S. Flemming, Chairman, U.S. Commission on Civil Rights, and immediate past Commissioner on Aging; Robert Benedict, Commissioner on Aging; Jay Harwood, Director, Albuquerque Area Indian Health Service; George Effman, NICOA Chairman (Sacramento Area); Juana Lyon, NICOA Executive Director.

Address by Dr. Arthur S. Fleming
Chairman, U.S. Commission on Civil Rights
(Awards and Recognition Banquet August 17, 1978)

I want to say that it's been an inspiration for me to have the opportunity to work with many of you, beginning with the Second White House Conference on Aging in 1971. I want to pay tribute especially to Mrs. Juana Lyon and those who have been associated with her for the quality of leadership that they have brought to their work. It has been an inspiration to me to see them come together with these issues and to deal with them in a positive and constructive manner. The whole field of aging is indebted to her for the quality of her leadership in the field of aging.

I also want to tell you that I appreciate being on this program with my successor, Bob Benedict. I knew, of course, Bob Benedict during the five years that he served as Commissioner on Aging for the Commonwealth of Pennsylvania. I regard him as one of the most effective and creative leaders in the field of aging. I was delighted when the President nominated him to the United States Senate as my successor. I have had the opportunity of observing him in action over a period of the past six months. He brings a commitment and creativity to this field that really is a source of great encouragement to all of us. You have seen that reflected and manifested here tonight as he has shared with you his plan for working in a cooperative manner as you engage in pioneering activities as a result of changes that are to be made in the law governing the relationships between the federal government and the Indian tribes in the field of aging. I know you are going to enjoy working with him in the months and years that lie ahead.

I want to, first of all, make sure of the fact that you are acquainted with the U.S. Commission on Civil Rights. I am confident that you will hear more about this commission in connection with the civil rights issues that confront your communities as well as issues in the field of aging.

This commission is a new agency as government agencies go, only twenty-one years of age. It came into existence in 1957 as a part of the Civil Rights Act that was passed that year. It is a bipartisan commission of six persons. The law specifies that no more than three members of the commission can be members of the same political party. All members of the commission are appointed by the President and confirmed by the Senate. In reality it is a citizens' commission. The full-time direction on a daily basis is handled for the Commission by the Staff Director, who is also appointed by the President and confirmed by the Senate.

From the very beginning, the commission has had two principal roles: first, to identify the basic issues in the field of civil rights, to study those issues through the help of its staff in Washington and in the field and through the help of its 51 State Advisory Committees. The commission also conducts public hearings. It then weighs the evidence, and makes findings and recommendations to the President and to the Congress of the United States.

The second role is to serve as a monitor for all departments and agencies of the federal government that have enforcement responsibilities in the field of civil rights.

From the beginning, members of the commission have felt an obligation to stay out on the cutting edge of all issues in the civil rights field. They feel they have an obligation to call the shots as they see them and to let the chips fall where they may.

Some of you are aware of the fact that presently one of the commission's projects is to investigate the way in which the civil rights of American Indians have been allegedly violated in connection with the administration of justice. Commissioner Freeman and I will conclude in a few days a hearing that we started a few months ago in Seattle, Washington, dealing with civil rights issues involving American Indians and the administration of justice. I was shocked at the hearing in Seattle, Washington, to listen to witnesses, including at least one State official, talk about abrogating treaties. We have come to a fine state of affairs, when any public official would openly advocate such a course of action. Soon after the first of next year, the full commission will hold a public hearing in the city of Washington, where we will look at these issues from a national point of view. When we have finished that hearing in Washington, we will evaluate the evidence and make findings and recommendations to the President and Congress of the United States. I want to say that the hearings in which I have participated, have really been eye-openers as far as I am concerned. I recognize that you have some very serious problems and I hope that our commission will be able to stimulate the kind of leadership that will result in those problems being resolved in a constructive manner.

In 1975, when the Older Americans Act was extended, the Civil Rights Commission was given a specific assignment in the field of aging. There was included in the Older Americans Act, what is known as the Age Discrimination Act of 1975. When members of Congress began to take a look at some of the problems in that area, they weren't quite sure they were ready to have that law go into effect. They specified that the law would not go into effect until January

of 1979. In the meantime, they directed the U.S. Commission on Civil Rights to make an in-depth of 1979. In the meantime, they directed the U.S. Commission on Civil Rights to make an in-depth study, to share some of our findings with you.

This Act, when it becomes effective, will make it unlawful to deny access to services or benefits that are supported in whole or in part by the federal government on the basis of age. We found in every federal program that we looked at in the course of our studies, glaring examples of discrimination on the basis of age. We identified discriminatory practices in such programs as the Community Mental Health, Comprehensive Employment and Training, Vocational Rehabilitation, Legal Services Corporation, and the Community Health Centers.

In the area of Community Health Centers, for example, we discovered that only 2% to 4% of those persons served were 65 years old and over. Yet the authorities in the field of mental health are unanimous in saying that 18% to 25% of the persons 65 years of age or over could benefit from mental health service.

We discovered that programs which the Congress clearly intended should serve all age groups were benefiting certain age groups—and not the older persons group.

When people talk about preventive health programs, we discovered that they were not talking about older persons. The fact of the matter is that there is a five-year program sponsored by the Department of Health, Education, and Welfare in the area of Preventive Health, but it is silent when it comes to preventive health as far as older persons are concerned.

When we had witnesses on the stand testifying under oath, we asked, how has this happened? Why is it that you as an administrator have taken a program that Congress intended for all age groups and administered it in such a manner that you have literally turned your backs on older persons? On a number of occasions, when we pressed hard enough, we got what we finally begin to realize was the real reason. They responded, "Well, we've got limited resources and we think taxpayers will get a better return from their investment if we concentrate those limited resources on children, young people and the middle aged, rather than concentrating on older persons.

They weren't always quite as blunt as this about it, but this message came through very clear to the members of our commission: After all, the older persons aren't going to be around for very long. Such an approach on the part of administrators at the federal, state or local levels is in direct conflict with the concept of the dignity and worth of each human being. Think what it does to a person to look that person straight in the eye and say: "Yes, we recognize that you have the need, but we've got limited resources and because you are in a particular age group, we are not going to use our limited resources for you in order to meet your needs. We are going to use them on people that are going to be around a little longer than you are." That kind of approach is in direct conflict with the dignity and worth of each person. Any policy that rests on that kind of foundation rests on a foundation of sinking sands.

The commission recommended, based on what it discovered in its studies and its hearings, that the denial of services on the basis of age should be prohibited by law. We felt there should be a forthright declaration on the part of Congress along this line.

In the Age Discrimination Act passed in 1975, there was some interesting language. It talks about preventing "unreasonable discrimination" and the law also talks about permitting "reasonable discrimination." As a result of our studies and hearings, the commission decided that there isn't such a thing as reasonable discrimination. All discrimination on the basis of age should be outlawed. We felt that Congress should strike out the words "unreasonable" and "reasonable."

We also felt that the Congress should give the individual, if he feels he is a victim of age discrimination, the right to sue in court.

The House of Representatives considered all of our recommendations and incorporated them into the 1978 extension of the Older Americans Act. In our judgment, if the Age Discrimination Act is finally amended in the way in which the House has amended it, we will have a law that will open up more resources for older Americans than are now available to older Americans under the Older Americans Act.

The Senate considered the extension of the Older Americans Act, but the Senate Committee didn't pay any attention to our recommendations for amendments to the Age Discrimination Act. As a result, the issue as to whether or not these recommendations are going to be incorporated in the law will be hammered out in conference between the Senate and House. I am delighted to learn that this council has taken a firm position in favor of the amendments as approved by the House of Representatives.

I can't begin to express really, in an adequate manner, the impact the experience of making this study had on the members of the commission. Here is what we said in our letter of transmittal: "The commission has taken notice of the fact that the Age Discrimination Act of 1975 is a part of the Older Americans Act. For this reason, we have given special consideration to the impact of age discrimination in the delivery of federally supported services and benefits on the lives of older persons. We are shocked at the cavalier manner in which our society neglects older persons who are often desperately in need of certain benefits. The reasons advanced for such actions are

devoid of feelings of respect and compassion for women and men, who have contributed much to their families, their communities and our nation. A vigorous and unequivocal implementation of the Age Discrimination Act of 1975 provides our nation with the opportunity to demonstrate by our deeds that we intend to do everything within our power to help make the last years, the best years of life."

As I've said to you earlier, the enforcement of this law will make all the difference in the world in terms of opening up additional resources for older persons. Older persons have not been getting their fair share of these federal services and benefits over the years. The time has come for them to get their fair share.

The Commission on Civil Rights was given a one-time assignment. But this was just the beginning of our involvement in the field of aging. First of all, in connection with the 1978 extension of the Older Americans Act, as it passed both in the House and Senate, the Civil Rights Commission is directed to make another special study about discrimination against older persons among minority and ethnic groups. We welcome that assignment and will undertake it with great enthusiasm. Also, in connection with the continued authorization of the Civil Rights Commission, both the Senate and House bills provide for the enlargement of our jurisdiction to include discrimination on the basis of age and handicap. That means, beginning with the next fiscal year, October 1, 1978, we will be in the age discrimination business on an indefinite basis. We will be in touch with all the departments and agencies of the government to see what they are doing about the enforcement of the Age Discrimination Act of 1975. If we find that they are not moving, once again we won't hesitate to get out on the cutting edge and call the shots as we see them and let the chips fall where they may.

So far as the Indian community is concerned, the U.S. Commission on Civil Rights is going to continue to be deeply involved in the civil rights issues that are troubling you, properly and rightly so, at the present time. The U.S. Commission on Civil Rights is going to be working hand in glove with you as we seek to bring about a situation where older persons will get their fair share of services and benefits financed by the Federal Government.

You have become a powerful force in the field of aging. Thanks for what you are doing and thank you for what I know you will be doing. I look forward to continue working with you.

Headtable at Awards Banquet enjoying Traditional Fashion Show. L to r: John Carlile, NICOA Vice-Chairman; Dr. Arthur S. Flemming, Chairman, U.S. Commission on Civil Rights; Robert Benedict, Commissioner on Aging; Jay Harwood, Director, Albuquerque Area Indian Health Service; Arlene Naquayouma (NICOA Member, Phoenix Area) narrating; Wendell Chino, Honorary Chairman; Mrs. Lillard; Sherman Lillard, NICOA Secretary; Sophie Thompson, NICOA Board Member and Conference Chairperson.

Excerpts of Address by Wendell Chino, Honorary Chairman of National Indian Council on Aging

(Awards and Recognition Banquet, August 17, 1978)

In the latter part of May, I had a wonderful opportunity, and I considered it a privilege, to address the World Peace Council in Basel, Switzerland. But coming back to this moment - this is even better, I think, a greater moment for me.

While in Switzerland, we had the opportunity to address some members of the Third World and some countries behind the Iron Curtain, representing over fifty nations. We went over there for the sole purpose of addressing the leaders of different parts of the world concerning the barbarism of democracy directed at Indian people today. You heard it already, some of the designated oversights on the part of the Senators and Representatives. Quite often, they have no inkling that the Indian wants to participate fully and adequately in the various programs designed by legislation. They tell us that we have no control over the "white eyes" on our own reservations.

I can go on and on and on to tell you about the violent acts of democracy. It is up to us as individual representatives here to go back home and attempt to persuade others to our side and to our position because we have a law of nations, but the law of public opinion is even greater than some of the laws written in the books. That is the only way we're going to survive as Indian people of this country. Because it seems that even the leadership of this country has forgotten justice, equality, brotherhood and love. They tell us, they do, but they have failed to prove it in all sincerity.

I came here to give a historical perspective of the National Indian Council on Aging. In 1971, the White House Conference on Aging drew some attention to the Indian elderly. This attention was focused on some major items.

Income—It is sad, when we talk about income with respect to our Indian elderly, indeed while Social Security may be available. You go back 50, 60 or 70 years and find that there were no employment opportunities for our people. Because they had nothing to their credit, certainly, they could not participate in Social Security programs.

Health—In health, we are behind the rest of the nation approximately 30 years. We are constantly suffering from the lack of funds. Surgical cases must be deferred because there are inadequate funds. As if you can postpone and cancel disease! In nursing homes, it is the same way. You would think that, in a land of plenty and in a country of might, that all ethnic groups would enjoy good nutrition. I am sad that our people don't even have the kind of nutrition that others have for their good health.

Housing — In housing, while the rest of the country was enjoying public housing, you and I were still living in shacks. We had to get the law amended to have the Indian participate in housing programs.

Legal — I have come to believe that, in this democracy of ours, it is not so much justice that rules. It is public opinion and the pressure put on, that decides the opinions so much of the various judiciary systems of this country. Let us be mindful of the fact that the system was not designed to help the Indian. Only by the grace of God, we became the recipients of the goodwill and generosity of some good people at some levels and branches of the U.S. Government.

Spiritual Well-Being — Our efforts have finally resulted in religious freedom for our Indian people.

Transportation, Education, and Physical Well-Being — These are some of the concerns that were generated at the 1971 White House Conference on Aging. In spite of the recommendations concerning the Indian people, they were ignored. Put on a shelf. During the years that followed, repeated attempts were made to revive these public issues that we have for our people — to no avail. Finally, in April of 1975, there was a conference on "Indians and Aging" at the Arizona State University, where these issues that I've mentioned surfaced again.

As a result, a very specific result happened at that Indian conference. One, "we must conduct a National Indian Conference on Aging." Such a conference may provide a forum for Indian elderly and Indian people, so that there may be a nationwide expression as to the needs of Indian people and the actions that may be necessary, as well as how these actions may be implemented.

Another thing that came out of the Arizona conference was that "we must bring about legislative actions, legislative provisions of the Older American Act that would be more responsive to the Indians and their needs." Again, the Older Americans Act was not too specific with regard to the American Indian. But, as a result, the third thing that happened was that a contact was made with the Administration on Aging in Washington, D.C., that requested funding for a national conference. It became apparent that a sponsor would be necessary and at that time, I was serving as President of NTCA (National Tribal

Chairmen's Association), and I was approached by the Phoenix Area Tribes to consider the sponsorship of such a conference. I readily agreed, and I placed the matter before the Board of Directors. The Board accepted the sponsorship of the conference.

We asked the Arizona Action for Elderly Committee to form the nucleus for placing the matter before their own group and to follow it up with planning and bring about a National Conference for Indian elderly. On October 27, 1975, the National Tribal Chairmen's Association submitted a proposal for the purpose of the national conference to the Administration on Aging of the Department of Health, Education and Welfare. The proposal was accepted and funds were made available.

So, on June 15 - 17, 1976, we had a conference in Phoenix, Arizona. There were 1,580 Indian and Alaskan Natives, representing 171 tribes, meeting together to form a consensus regarding some of the tragic needs that exist among us. As usual, the First National Indian Conference on Aging did not make extravagant demands on the administration or upon this country. The conference only asked that the Indian people be allowed to live out their lives with the assurance that their most elementary needs be taken care of with regard to food, clothing, shelter, health care, etc. The elderly stated at the First National Indian Conference on Aging that they wanted to remain Indian. Whether as a part of a sovereign nation, insisting upon our treaty commitments, or as individuals who want to pass on the heritage of their forefathers to their grandchildren.

The leadership of the country, both in the White House and in the Congress, they are accusing us of making excessive demands by making reference to the treaty obligations. We were told by different leaders from different parts of the world that if Indian treaties are not worthy of recognition then no other treaty with other parts of the world is worthy of recognition. I do not believe that these treaties make excessive demands upon the country for they refer to only simple matters that affect all of us as citizens of this country. Yet, people tell us, let's abrogate the treaties! Let's take Indian water, let's take Indian resources! So once you violate these historic documents, what is to follow — the displacement, the destruction of the Indian society. So, all we are asking, the Indian elderly asked, at that first National Indian Conference was: recognize us as a party to a historic document in this country!

The recommendations of the 1976 Conference are being distributed at this conference. The 1976 Conference was a fruitful conference. Out of it came the National Indian Task Force on Aging, and that Task Force evolved into the National Indian Council on Aging, which every one of you is a part of today. It also asked for the establishment and the maintenance of continuous communication between the National Indian Council on Aging and the Administration on Aging, as well as with other federal agencies, which is being done today.

Out of the conference also came a conference report that numerated the problems and unmet needs of our Indian people. This same report contains recommendations for future and remedial actions. The communications that developed at that conference continue today as a definite result. One result is that there must be a development and a regeneration of greater sensitivity for the needs of the American Indian. For the American Indian elderly, specificially. There must be an ongoing effort to meet the needs of the Indian elderly. These needs are so great!

Our problems really need a realistic look, an in-depth look, and they can be solved. We appreciate the fact that the National Indian Council on Aging acts in the role of client representative so that greater sense of sensitivity may continue. Only time will tell as to the positive benefits of these efforts. I am sure that the Council attempts to make it its business to assure that some of the services denied to us be henceforth coming to our elderly.

Not too long ago, I was reading some of the recommendations by Indian Bureau superintendents regarding the reorganization of the government in the Carter Administration. One of the glaring omissions of the superintendents is that they failed to recommend that these outdated laws — century old regulations — be allowed to stay and everything be made current to fit the present day Indian. They want us to live under 1848 regulations, so they keep telling us, there are social services available. They find new regulations that prohibit that service. So, this is why we need to become more flexible and discard some of these old regulations. Even where it is annotated, if at all, it is inadequate.

Personnel, decision-making and client contact positions lack sensitivity to the culturally based needs of the elderly. The tribal governments are subject to discrimination by laws, policies, denying us the right to participate as self-governing units of general purpose local government and to provide services to the tribal people, when we can be prime sponsors and administrators for the Indian elderly. They say there are services available, but you must go through the county or state channels. Consequently, we are victims of the manipulations of outside policies. This is why county or state channels. Consequently, we are recognized tribes are victims of discrimination. They are not always being dealt with on an equal basis with the State, in spite of the fact that there are treaties that say that they should be treated so. The denial of direct access to where these funds come from makes it

difficult for all of us. This is why we clamor and work for direct funding from the government.

Two weeks ago, I had the opportunity to address the Western States Democratic Party meeting in Santa Fe, New Mexico. I told these people, don't take the Indian vote for granted. The point is that Indians are here, and we do not intend to go away. We are going to be here. I want to say to this country and the world that, if the Indian people are not worth saving, then there is no race of people that is worth saving!

So, let us learn how to live together and not how to die together! This is why we are asking for the sensitivity to our special relationship with the United States government, particularly the federally recognized tribes. Coupled with this sensitivity, there must be service commitment. Special and unique services, because poverty and geographic isolation continue to plague us. So, ladies and gentlemen, there must be a sincere desire to alleviate the tragic conditions among our Indian elderly and our Indian people, for that matter.

We hope that the Congress and administration know that there must be a coordinated effort before these problems can be resolved, for the paramount purpose of the National Indian Council on Aging is to provide advocacy for Indian and Alaskan Native elderly. There must be the realization of remedial action. There may be recommendations that will be made the business of today's conference. Since its inception and founding, the National Indian Council on Aging has established and maintained a cooperative relationship with the Administration on Aging. We have been involved with a network on Aging on all levels. We have been working with the Indian Health Service and Bureau of Indian Affairs; they are cooperating and maintaining the office in Albuquerque. The National Indian Council on Aging has worked to provide that amendment to the Older Americans Act and has given a high priority as part of their recommendations to direct funding to Indian tribes.

NICOA has worked with the Senate Special Committee on Aging, chaired by Senator Frank Church, and the House Select Committee on Aging, chaired by Rep. Claude Pepper, with the hope that the direct funding to tribal governments may become a reality. The direct funding to Indian tribes has been a constant voice of Indian tribes since the 1976 conference, and it continues today. For this to become a reality, you and I must be involved. The National Indian Council on Aging should be justly proud of this effort.

Wendell Chino, Honorary Chairman, National Indian Council on Aging, and President, Mescalero Apache Tribe of New Mexico

Statement of Senator Frank Church*
Information Exchange
August 18, 1978

As Chairman of the Senate Special Committee on Aging, I extend my welcome to this "Information Exchange," and again express my regrets that Senate legislative responsibilities make it impossible for me to be with you. However, your concerns and feelings will be conveyed back to Washington by Committee staff so that we may continue to evolve Federal aging policies and programs which give consideration to the special needs and conditions of older Indians.

This Conference, like the one held in Phoenix two years ago, offers a unique opportunity for the Indian elders, in whom reside the cultural tradition of the Indian nations, to express themselves. Therefore, while the Committee staff will be happy to answer any questions and provide information, today's "exchange" is really for the purpose of hearing from you, and my message will be brief.

The Congress is nearing final action on extending the Older Americans Act.

The Act was first passed in 1965, with four major purposes:

1) To establish an Administration on Aging as the central Federal spokesman for the elderly.
2) To develop a community-based delivery system for services which promote continued well-being and independence.
3) To fund research and development programs for the testing of innovative programs.
4) To fund training grants for the personnel needed to staff these new aging programs.

A major assumption underlying the Act was that all America's elderly had the right to benefit from its programs. Therefore, any older person may seek the assistance it provides without proving income under a "means test."

In 1973, a national network of Area Agencies on Aging began to take shape. Their number now stands at 563. The expansion of Federal services to the elderly can also be gauged by the large increase in funding since the Act's inception. In 1965, only $7.5 million was appropriated under the Older Americans Act; in 1978, appropriations had grown to almost $700 million; and authorization levels of more than $1 billion annually are set in the new bill just approved by Congress.

There are differences between the two bills passed by the House and Senate, and these will be worked out through negotiations in Conference. While it is impossible to predict the final shape of the law, I do want to describe some of the provisions of the Senate bill of special importance to older Indians——

—Two new studies are mandated to make sure that minority group elderly, including Indians, are not being discriminated against in Federal programs. One would be conducted by the Federal Council on the Aging, and the other by the U.S. Commission on Civil Rights.

—The Commissioner on Aging is authorized to directly fund Indian tribes, at their option, for services under the Act. A total of $61 million is set for Fiscal years 1979 and 1980 for the direct funding of tribes and for the conversion of surplus reservation schools into multiservice senior centers. Funding will be based on verified tribal statistics, not on outdated and inaccurate Census Bureau figures. Also, the Secretary of Labor is permitted to enter into direct agreement with the tribes for senior community service employment programs.

These are important breakthrough provisions. I fully support them, in large part due to the effective case made at hearings by representatives of the National Indian Council on Aging.

—The Senate bill also permits the Commissioner on Aging, in situations where an Indian reservation crosses State borders, to establish a single, comprehensive planning area for that reservation.

—Finally, a 1981 White House Conference on Aging is authorized to provide a national forum for the assessment of the progress of older Americans since the 1971 Conference, and to plan for the future. Your activities during the period between now and that Conference should focus on developing information on the status of the Indian elders, which can be evaluated in 1981 and provide the basis for recommendations for action.

* Presented by Philip S. Corwin, Professional Staff, Senate Special Committee on Aging.

There are, of course, other issues of concern to you besides the Older Americans Act. There is a great need for on-reservation long-term care centers which can serve your elders within a familiar environment close to friends and family. I also hope you will let Committee staff know the extent to which Federal programs are able to help you build new housing, and weatherize and rehabilitate existing homes. Good transportation is essential if you are to be able to take advantage of the full range of services under the Older Americans Act and other Federal programs. Committee staff are working with a special White House Task Force on rural transit needs, and want to hear from you. Finally, special attention must be paid to the older Indian living off-reservation in the city. The Committee will soon be undertaking a new series of hearings on Older Americans in the Nation's neighborhoods, and we want whatever information you can provide on the status of the urban Indian elders.

Again, I express my regrets at being unable to meet and speak with each of you personally today. But the Committee staff will report directly to me and the other Senators on the Committee on Aging. With the advice and advocacy of the Council, we have joined with you to change Federal law to better serve you. You have made great progress in the two years since the Phoenix Conference, and you can be sure that I look forward to working with you through the years ahead.

LAWTON CHILES, FLA., CHAIRMAN
FRANK CHURCH, IDAHO
JOHN GLENN, OHIO
JOHN HEINZ, PA.
DAVID H. PRYOR, ARK.
BILL BRADLEY, N.J.
WILLIAM S. COHEN, MAINE
G. CHRISTIAN LEMMER, STAFF DIRECTOR
DAVID A. RUST, MINORITY STAFF DIRECTOR

United States Senate

SPECIAL COMMITTEE ON AGING
WASHINGTON, D.C. 20510

August 16, 1978

COPY

Mr. Wendell Chino
Honorary Chairman
National Indian Council on Aging
P. O. Box 2088
Albuquerque, New Mexico 86103

Dear Wendell:

Best wishes to you as you convene the National Indian Conference on Aging. I hope that the Conference will be a tremendous success, and regret that a heavy legislative schedule precludes my being with you in Billings.

I am sending in my stead two staff members on the Minority Staff of the Senate Special Committee on Aging, Dr. Letitia Chambers and Mr. Jeffrey Lewis are both very knowledgeable in the fields of Aging and health care. I know you and those in attendance will find their contributions both helpful and informative.

I remain committed to improving the delivery of health care services to all American Indians. The reports my staff provide will enable me to gain a better perspective on the overall health care needs. I will share these insights with my colleagues in the hope that we can all work together to upgrade the scope and quality of the health care services provided to all American Indians.

Again, my best wishes for a successful Conference. Please convey my greetings and warmest regards to all those in attendance.

Sincerely,

Pete V. Domenici
United States Senator

PVD:ew

JOHN MELCHER
MONTANA

United States Senate

August 14, 1978

Sophie D. Thompson, Chairperson
National Conference on Aging
Montana Convention Center
Holiday Inn West
Billings, Montana

Dear Ms. Thompson and Delegates:

I extend to all of you my best wishes for a very successful and productive Indian Conference on Aging. The heavy schedule of Senate business keeps me from being with you today. But as a member of the Senate Special Committee on Aging and as a member of the Senate Select Committee on Indian Affairs, I am particularly interested in the outcome of this gathering.

The subjects your conference brings together -- Aging, Native Americans, and health needs -- are among the most important facing the nation today.

It is, both, as a member of the Senate Aging Committee and the Senate Indian Affairs Committee that the needs of the elderly are made most evident to me. Much too often, the elderly are forced to make choices among whether they will eat, or stay warm, or obtain medical treatment because they do not have enough money.

That is a modern tragedy and it is entirely wrong.

At times, when a program is created for the elderly, some say that is welfare or charity -- and that is wrong, too.

Whatever can be done for older people is simply a case of America paying some small return on the investment people have made in our country.

The Senate has taken some steps this year to improve programs for the elderly. When the Older Americans Act passed in July, it provided that federally recognized tribes would have the option of applying directly to the Commissioner on Aging for social and nutrition services under that Act. Tribes would also be allowed to develop their own population figures when applying for that funding and the Secretary of the Interior would be directed to make available surplus educational facilities to tribes for use as multipurpose senior citizens centers.

440 RUSSELL BUILDING WASHINGTON, D.C. 20510 (202) 224-2644

When the Senate passed the Health Planning Amendments in July, it set up a National Commission on Alcoholism. Senator Domenici from the Senate Aging Committee amended that so that Native Americans would be included under the study provisions. Moreover, a section of that bill underlined the fact that Indian tribes are to remain the sole authority for health planning and development on their reservations.

These may be steps in the right direction. But we have not moved much beyond the stage of looking at the compass to find out which way to go. There is plenty to be done and I am hopeful this conference will help plot the course.

All of you know only too well that the history of this continent has been a continuing struggle for personal independence. Long before there was a Federal Government there were ancient people here who took their strength from the land and their faith from harmony with land and water and wildlife and the people. That tradition found its way into the Declaration of Independence when Thomas Jefferson wrote that people have the right to strive for the equal station to which the laws of Nature and of Natures God entitle them.

That is not a gift of government. That is the right of the people. We must commit ourselves to making sure that right is strengthened and protected.

Best regards.

Sincerely,

John Melcher

Appendices

APPENDIX A

Social and Psychological Status of the Indian Elderly: Past Research, Current Advocacy, and Future Inquiry

Spero M. Manson, Ph.D., and Audra M. Pambrun, R.N., D.Sc.*

This paper traces the history of efforts at the national level to improve the quality of life for the Indian elderly, with special reference to mental health. Relevant literature is critically reviewed and discovered to be limited theoretically as well as substantively. Partial results are presented from a survey conducted among elderly Indian participants in the Second National Indian Conference on Aging held in Billings, Montana, 1978. Their images of themselves and feelings about family and community response to their particular needs are discussed. General trends are compared with similar findings from studies of elderly members of the dominant culture.

ACKNOWLEDGEMENTS

The authors wish to acknowledge the support of the following people and agencies: 1) the Portland Area Office, Indian Health Service (in particular, Dr. Stan Stitt and Mr. Al Folz) and the Second National Indian Conference on Aging Planning Committee for facilitating conduct of the survey from which results are partially reported herein; 2) Ms. Juana Lyon and Mrs. Alice Norris for providing added historical information; 3) Ms. Susan Sheoships, Ms. Dianne Kelso, and Mr. John Spence for tabulating and coding the survey data, and 4) most importantly, the Indian elders who gave of their time to complete the questionnaire. Of course, the authors are alone responsible for any inaccuracies, oversights, or omissions in this paper.

INTRODUCTION

Recent public and scientific inquiry into the status of elderly Americans has become increasingly critical and comprehensive in scope. Newspapers regularly publish debates about the impact of mandatory retirement, social security benefits, and tax regulations upon the aged. Other media detail human interest stories which reflect housing problems, inadequate transportation, and numerous barriers to the provision of services to them. Likewise, in the last decade, four academic journals have appeared as a forum for research conducted within the relatively new field of social gerontology. Clearly, this particular life experience has never been more closely scrutinized and elderly Americans have never been given more hope for its improved quality.

Yet, a general omission is apparent: the elderly in question are usually white, seldom black, and **never** Indian. What is the current social and psychological status of the Indian elderly? How do they feel about that status? In what ways do they believe that it can be enhanced?

This paper traces the history of the most widely recognized advocate for improving the elderly Indian life experience: the National Indian Council on Aging (NICOA). It summarizes the mental health issues which arose during two national Indian conferences on aging and reviews relevant literature. Lastly, this paper reports some results from an extensive needs assessment of participants in the most recent NICOA conference, adding another dimension to a still unclear picture.

ADVOCACY

One impetus for John F. Kennedy's "War on Poverty" is reported to have been **The Hidden American** by Michael Harrington (1960), to which the former president often referred. The Community Action Programs, administered through the Office of Economic Opportunity, were the result of Kennedy's political philosophy. These and similar programs, coupled with indigenous socio-cultural mechanisms, encouraged the first systematic articulation of elderly Indian needs and sentiments.

In the ensuing years, however, close examination of the status of elderly Indian people, planned improvement, and the search for long-term legislative remedies proceeded only at the local level. Examples include the Papago Tribe's Program for the Elderly, Navajo Aging Service and Senior Citizen Councils. During the Western Conference on Aging held in Portland, Oregon, early 1971, several Indian members of the National Council on Aging's Board of Directors successfully focused federal attention on these efforts. Continued advocacy culminated in a Special Concerns Session on the Elderly Indian at the December, 1971, White House Conference on Aging. The particular

* White Cloud Center

needs of elder Indians were set forth within eight categories: 1) income; 2) housing; 3) legal; 4) nutrition; 5) nursing homes; 6) health; 7) transportation, and 8) education, physical and spiritual well-being. Indian delegates recast the discussion of such needs as a set of explicit recommendations (Summary Report, 1972). Those specific to mental health called for funds to organize and conduct culturally oriented activities ranging from social clubs to educational classes, to employ the elderly as resource persons within culture preservation programs, to match the age, sex, and tribal background of social service providers and elderly recipients, to reorient service delivery to individual home-care as opposed to institutionalization, and to support traditionally therapeutic methods of modifying drinking behavior. There is no evidence that the government acted on any recommendation in the area of mental health or otherwise.

Subsequent attempts to maintain a national dialogue on these issues fell far short of previous outcomes. For example, the 1973 Post-White House Conference on Aging noted minorities only in passing and ignored the Indian elderly.

April, 1975, Arizona State University sponsored a conference titled "Indians and Aging". The participants represented the most active and well-organized segments of the elderly Indian community. From among them emerged a caucus which reformulated the elderly Indian position. Its objectives included a national conference "to provide a forum for the Indian community nationwide to state its unmet needs, recommend remedial action, and press for implementation of that action" (Lyon, 1978, p. 1). Eight caucus members were selected to pursue this and other objectives. They, in turn, formed a steering committee, "Arizona Indian Action for the Elderly", chaired by Alice S. Norris, Director of the Papago Tribe's Program for the Elderly.

Late in the same month, Senate Subcommittee hearings on amendments to the Older Americans Act demanded immediate attention. Thus, the energies of the Arizona Caucus were momentarily focused upon seeking legislative action which would render Titles III and VII more responsive to elderly Indian needs.

Establishment of a national Indian conference on aging subsequently assumed highest priority. Juana Lyon, then the Indian Specialist of the Arizona Department of Economic Security, was delegated responsibility for soliciting conference support. Meanwhile, the steering committee was enlarged, representation extended to the Arizona, Nevada, and Utah tribes (equivalent to the Phoenix Area, Bureau of Indian Affairs), Navajo Nation, and major urban Arizona Indian organizations. This reorganization reflected an interaction which had developed in response to the Senate Subcommittee hearings mentioned above.

Conference funding required sponsorship by a national Indian organization. The Board of Directors of the National Tribal Chairmen's Association (NTCA), with the assistance of Wendell Chino, then president, officially accepted this role, and authorized the Arizona Indian Action for the Elderly Committee to plan and conduct conference activities. A grant proposal was formulated and submitted to the Administration on Aging (AoA), Department of Health, Education, and Welfare in October, 1975. AoA approved it and awarded nearly $200,000 for the first conference, specifically setting aside over 60 percent of this amount to enable direct participation by Indian elderly.

Through the NTCA, two levels of planning were organized: state or area committees and a national committee. The former's purpose was to: 1) define subject areas for potential discussion; 2) identify individuals who could address these areas; 3) forward this information to the national planning committee, and 4) publicize and coordinate local conference participation. The national committee was composed of the NTCA president, a representative from each of the twelve NTCA areas (usually the NTCA delegate), and one or more community leaders from the largest sectors of the Indian population across eighteen states. Under the direction of Juana Lyon, as project coordinator, its members supervised all conference activities. A widely distributed "problems and needs" questionnaire provided additional input.

The First National Indian Conference on Aging was held in Phoenix, Arizona, June 15-17, 1976. Approximately 1,500 people attended, representing a broad range of interested parties: for example, not only the Indian elderly, but tribal governments, urban and rural, non-reservation organizations, regional and national AoA offices, state and area agencies on aging, service programs both specific to and supportive of the Indian elderly, as well as select congressional leaders. The five workshops and conference recommendations mirrored the yet unresolved concerns which had surfaced at the earlier White House Conference on Aging. Discussion centered upon income, environment, legal problems, health, and legislation. Mental health policy recommendations were essentially the same as those adopted in 1971. However, the importance of basic research became apparent, for planners still lacked the data with which to justify, design, and evaluate the desired programs. Hence, a "thorough and complete research program" was specifically recommended.

Past efforts to influence national policy failed largely because no mechanism had been provided to coordinate legislative follow-through and document need on a continuing basis. Having recognized this,

the First National Indian Conference on Aging called for reassignment of national planning committee members to a permanent Indian Task Force on Aging. Five conference participants were added to it. The Task Force incorporated as the National Indian Council on Aging and successfully applied for three years of AoA financial support with a substantial in-kind contribution by the Bureau of Indian Affairs (BIA).

In rapid succession, NICOA established working relationships with the National Network on Aging, Indian Health Service, House Select Committee on Aging, U. S. Commission on Civil Rights, and other Department of Health, Education, and Welfare offices. Various advocate programs and positions were proposed to these agencies. An Indian Liaison Specialist was added to the AoA staff; a Second National Indian Conference on Aging was funded. But a more far-reaching effort to enable Indian organizations to identify and access money to develop individual aging programs did not receive support. A research project which proposes to examine the effects of lower life expectancies, geographic isolation, service disparities, and cultural assumptions upon the aging process of the Indian elderly remains tentatively approved without funding. Four state-level Indian councils on Aging (Arizona, Navajo, Idaho, and Oklahoma) have been organized and pursue similar objectives within their respective communities.

Employing the same organizational network, the Second National Indian Conference on Aging was convened in Billings, Montana, August 16-18, 1978. Its theme, "Continuum of Life", addressed various aspects of the elderly's well-being and personal environment. Nearly 2,000 people registered, representing the full range of previous participation. The agenda included 17 workshops, three of which focused specifically upon the social and psychological status of the Indian elderly. Their repeated concerns were "to have better health care, to be active, to be self-sustaining, to advise and be advised on programs affecting them, to choose how and where to live in their advanced years and to be re-educated; thereby being able to maintain a personal dignity as contributing members of their Indian communities" (York, 1978).

RELEVANT LITERATURE

A growing literature explores the social, psychological status of elderly members of the dominant culture in considerable detail. Areas of inquiry include socialization (Roscow, 1974), community dynamics (Cumming et al, 1960; Henry, 1959; Hochschild, 1974; Kutner et al, 1956; Townsend, 1957), individual motivation (Filer and O'Connell, 1964), personality measures (Thaler, 1966, 1971), and psychiatric aspects of adaptation to aging (Perlin and Butler, 1971). Numerous handbooks outline past and future research directions (e.g., Barron, 1961; Birrin, 1959; Clark and Anderson, 1967; Neugarten, 1968; Simpson and McKinney, 1966; Tibbitts and Donahue, 1962).

In contrast, a thorough review of the social and health sciences literature indicates that only 18 publications even remotely examine the psychosocial dimensions of the elderly Indian life experience. Of these, Goldstine and Gutmann (1972) and Krohn and Gutmann (1971) depict the male aging process from a strongly psychoanalytic perspective. Both employ projective imagery—dreams and TAT responses, respectively—to assess age differences in ego mastery styles. Differences are evidenced between younger (35-54 years) and older (55-95 years) Navajo men, with a major shift from active to passive and magical strategies of relating to the world.

Richek et al (1971) and Lewis (1941) investigate the adaptive strengths of women in their later life stages. Richek et al develop hypotheses about disengagement processes in aging, proposing differences across ethnic membership. Preliminary findings suggest differences between elderly Indian women (largely Choctaw) and Caucasian women in disengagement from children, authority, work, and parents, as well as in terms of self-esteem and attitudes toward personal environment (elderly Indian women exhibiting significantly higher self-esteem and greater optimism). Lewis describes a constellation of behaviors which the North Piegan Blackfeet characterize as a "manly-hearted woman" (ninauposkitzipxpe). Relative to other adult Blackfeet females, such a woman is allegedly more independent, ambitious, aggressive, bold, and enjoys greater social freedom. Seniority (mean age = 60 years), economic affluence, and political acumen are closely associated with this status.

Opler (1936, 1938) discusses age differences in ritualized grief reaction and in attitudes toward one's own death. Comparing Chiricahua, Mescalero, Lipan, and Jicarilla Apache ethnographic data, he postulates an inverse relationship between death-related fear/anxiety and age: simply, older people are less fearful and less anxious than younger people about their and others' deaths. This relationship presumably reflects individual sense of social fulfillment. French and Schwartz (1973) briefly consider the death of an elderly Navajo woman, her response to a terminal prognosis and the solace she found in a traditional healer.

Boyer et al (1964, 1965) report the effects of acculturative pressures upon the personality structures of elderly Mescalero and Chiricahua Apaches. Again psychoanalytically oriented, they employ Rorschach data to conclude that certain psychological character-

istics vary between the two groups, are related to historical conditions, and can be explained by their different approximations of Euro-American values.

Leighton and Hughes (1955) describe Eskimo suicide from a functional viewpoint, arguing that it serves a purpose for elderly members in particular and for the social group generally. According to their argument, suicide not only ends individual physical or psychosocial suffering, but may also be highly valued. To the community, self-inflicted death means less drain upon limited resources without the disruption of other solutions such as murder or infanticide.

Hurt and Brown (1965) distinguish age-specific patterns of social drinking among the urban Yankton Sioux. Younger and older men apparently differ in terms of group size, topics discussed, kind and amount of intoxicant consumed, bars frequented, and their relationship to female Indian patrons. Women exhibit a similar trend, but also vary in time spent drinking and willingness to interact with non-Indians.

An Advisory Council on the Elderly American Indian statement (1971) emphasizes the mental health benefits of Indian family solidarity. It calls special attention to the elder's role and psychosocial support that members derive from him/her. McClure and Taylor (1973), with recent clarification by Taylor (1975, c.f. Bell et al, 1976), provide additional, though limited evidence of this contribution. Chevan and Korson (1972), in turn, note the importance of family to the emotional stability of widowed Indian elderly.

Little and Shoop (1972) survey local attitudes toward extended care services for the elderly on or near the Gila River Reservation. Their work suggests that some deleterious effects of institutionalization (e.g., psychological distress, fear, rejection) may be ameliorated by Indian as opposed to non-Indian staff and facilities.

A paper by the Association of American Indian Physicians (1978) analyzes mental health diagnoses of elderly patients seen in Indian Health Service clinics and hospitals during the 1975 fiscal year.* Neurosis (anxiety, depression) and psychosis are specifically identified, as are broader categories such as alcoholism, drug abuse/dependence, and suicide. Relative incidence is compared both between and within age groups. The findings indicate that: 1) the elderly are diagnosed as neurotic no more frequently than other age groups; 2) the elderly are diagnosed as psychotic, alcoholic, and drug dependent significantly less often than other age groups, and 3) elderly Indian males commit suicide much less frequently than elderly white males. The caseness pattern among elderly Indians reveals 52 percent neurotic, 18.6 percent alcohol-related, 14.5 percent undefined, and other categories ranging from 7 to 1 percent.

In his general profile of the elderly Indian, Benedict (1972) presents data—previously published and unpublished—from numerous Department of Health, Education, and Welfare sources. He specifically considers population characteristics, educational attainment, employment, income, and health status. Hill and Spector (1971), comparing Indian and non-Indian natality/mortality rates, provide further insight into the elderly Indian's social environment. Bell et al (1976) retabulate 1970 census information and demonstrate that their income (median males = $1,554; females = $1,162) and extent of education (mean = 6.6 years) are lowest across the nation. These authors essentially agree that "the Indian elderly could very well be the most deprived identifiable group of American citizens" (Benedict, 1972, p. 51).

A reading of the literature indicates that it is severely limited not only in size, but by a heavy psychoanalytic emphasis, basically descriptive design, and its dependence upon nonrepresentative service agency information of questionable reliability. There is little sense of understanding Indian elderly in their own terms. How do they preceive the quality of life? What do they view as problematic? How do they cope with and adapt to life situations? What do they believe to be their strengths; weaknesses? How do they signal need? When do they seek help; from whom? The concept of "elder"—how, when, and to whom applied—is treated as obvious and straightforward. Conflicting age categories (e.g., 45 years and older in one study and over 60 years in another) and exclusively chronological definitions at the expense of ignoring a complex system of social markers suggest that the concept requires closer examination.

SURVEY OF NATIONAL INDIAN CONFERENCE ON AGING PARTICIPANTS

With NICOA approval and assistance, a health needs assessment was conducted among participants in the Second National Indian Conference on Aging. It sought to collect information about physical status, service utilization, self-image, and perceptions of family and community response to elderly needs. Data from the last two of these four areas are reported herein.

Subjects

One thousand three hundred questionnaires were

* Association of American Indian Physicians. Aging: its impact on the health of American Indians. Paper presented at the Second National Indian Conference on Aging, Billings, Montana, August, 1978.

distributed through registration materials. A brief announcement during the opening remarks called attention to the survey and encouraged participation, but stressed its voluntary nature. Two hundred sixty-one questionnaires were returned, a 20 percent completion rate. The sample was, of course, self-selected.

Twenty-seven different states were represented; a majority of the respondents were from Arizona, Montana, New Mexico, Washington, Oklahoma, Nebraska, and South Dakota. Members of 67 tribes responded. Sioux, Navajo, Chippewa, Papago, Pima, Assiniboine, and Gros Ventre accounted for half of the respondents. Reservation communities (51%) were more represented than either urban (42%) or non-reservation, rural (7%) communities.

The average age of the respondents was 57 years. Primarily female and from large families, they were high school educated and usually married—though a significant portion were widowed. Nearly three-fourths were employed full-time in markedly professional occupations (e.g., social workers, teachers, health care paraprofessionals). More than half were full-blood Indian, and almost all indicated greater than one-half blood quantum. A considerable number spoke their native Indian language fluently.

Results

One set of questions provides a means of roughly estimating the respondents' satisfaction with themselves as individuals. Respondents noted in simple yes/no fashion whether they were proud of their personal appearance, had attained most life goals, felt good about themselves, functioned adequately, and liked the present quality of their lives. In aggregate form, the answers to each question were consistently and significantly affirmative (binomial test, p less than .001). No significant difference in this pattern of response was evidenced during separate analyses of the potential effects of respondent sex and marital status (chi square test, 1 df, p less than .05). However, residence did make a considerable difference. Reservation community members answered significantly more affirmatively to four of these five questions than did non-reservation community members (chi square test, 1 df, p less than .01).

Another set of questions addresses the respondents' perceptions of their interaction with family and community: more specifically, the available human resources and local sensitivity to aging and consequent needs. Consider family-specific items. Respondents were first asked if family had room, could care for, and would respect them. Only slightly more than half reported that their families had room and could care for them. A significant number (binomial test, p less than .01) thought that their families would think less of them. Respondents tended to believe that they too would respect themselves less (binomial test, p less than .10). They clearly did not wish to live with either immediate family (binomial test, p less than .01) or more distant relatives (binomial test, p less than .001). Not surprisingly, a very significant portion (binomial test, p less than .001) concluded that they as elderly people should live in their own homes. These sentiments did not differ significantly across sex, marital status, or residence.

Only half of the respondents reported that their peers were satisfied with community response to elderly needs; more than one-third believed that they were not satisfied. This perception was not altered by sex or marital status. Dissatisfaction was expressed significantly more often by members of urban communities than by members of reservation communities (chi square test, 1 df, p less than .01). The former's communities were thought to have planned significantly less entertainment for them (chi square test, 1 df, p less than .001) and its members tended to feel more isolated (chi square test, 1 df, p less than .10), though they claimed to have no greater transportation problem than that experienced on reservations. When asked if their tribal councils were "doing a good job", respondents from reservation communities with planned entertainment answered significantly more affirmatively than respondents from reservations which did not plan such entertainment (chi square test, 1 df, p less than .001). A similar relationship was evidenced in an analysis contrasting reported tribal council effectiveness and personal transportation problems (chi square test, 1 df, p less than .01).

Discussion

Several limitations in the data must be acknowledged prior to a discussion of the broader implications of the above results. These limitations are related to various aspects of the sample and its relevance to Indian elders at large. First, since respondents selected themselves, one can neither identify the individual biases that led people to participate nor determine the extent to which these biases may have been shared among them. Second, the respondents were dramatically better educated and more often employed than the elderly profiled by Benedict (1972). Third, terms such as "the Indian elderly" can be misleading. The Indian community is extremely heterogenous, comprised of hundreds of tribes and described in terms of culture areas which have ranged from 7 to 17 in number. Hence, this sample should not be interpreted as statistically representative of **all** Indian elderly. But it does reflect their sentiments in another, equally important way. Conference participants were nominated and selected for their ability to

articulate local concerns. Through them, the Indian elderly are making known their position.

The findings in this survey confirm York's observation of the mood of conference participants in particular and Indian elders generally. They do indeed wish to be active, to be self-sustaining, to choose how and where to live. Personal dignity is tied to these aspirations, whether male or female, married or not. The nature of one's community seems to differentially affect their actualization. Yet the importance of these findings extends beyond simply documenting informal conclusions. Elderly likes and dislikes, concerns and priorities can now be compared across ethnic boundaries.

Hochschild (1973, p. 27) states that most elderly Americans live in their own homes. Eight-four percent of those who do also live within one hour's drive of a child, and may see this child as often as every one or two days (Riley and Foner, 1968). Likewise, nearly all survey respondents maintain their own homes. Distance from their children cannot be ascertained from the data; however, given that a majority of the respondents reside on reservations, one can speculate that they too live near at least one child and see them frequently. Beyer and Woods (1963), in a national survey of elderly American attitudes, report that most do not **want** to live with their children: specifically, more than 90 percent. In the present survey, the Indian elderly responded in almost identical fashion. Such sentiments do not necessarily mean that family life is unimportant. On the contrary, the quality of family life appears to be consequently enhanced and more highly prized (Hochschild, 1973, p. 28). A similar relationship may characterize the experience of Indian elders, but remains to be investigated.

A series of studies indicate that as the number of elderly people within another elderly person's social sphere increases, he or she will feel less isolated (Blau, 1961; Messer, 1966; Roscow, 1961, 1962, 1967). Again, extrapolating from the differences between urban and reservation Indian elderly in their self-reported isolation—and, according to the available census information, given that more elders probably live within the latter type of community—a similar dynamic appears to be operating among this population as well. Furthermore, dominant culture family relations become more positive as actual contact with other elderly persons increases (Bultena and Wood, 1969; Hochschild, 1973). Additional research must be conducted before one can determine if a similar condition applies to the Indian elderly.

To date, social gerontological research has identified several major contemporary pressures which affect the elderly American: 1) a decline in work and employability; 2) the development of age-stratification, and 3) the relative weakening of kinship ties. Combined, they herald a remarkably different kind of interaction between young and old. Elderly Americans are re-conceptualizing their role in light of this new relationship, seeking support and approval from other elderly Americans, not just family. We do not know the extent to which Indian elderly are subject to similar pressures, may be interacting differently with their younger people, and have adopted other social and psychological benchmarks. It is time to inquire.

CONCLUSION

The popular image of Indian elders places them in their children's homes, caring for the young, respected in turn, and totally dependent upon these circumstances for a sense of self-worth and fulfillment. Communities presumably provide social and psychological support by seeking their counsel and apprenticing members to them to preserve rare skills and valued knowledge. The relevant literature is dated, limited theoretically as well as substantively, and provides no insight into this image. Current advocacy demands that it be critically re-examined and that future literature not only address immediate concerns, but offer information applicable to possible solutions. Results from the survey reported herein suggest that at least some parts of the prevailing image of Indian elderly are inaccurate, probably "age-centric", and can be more profitably investigated when the elderly's view of themselves is taken as a point of departure.

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APPENDIX B

Alternatives for Planning a Continuum of Care for Elderly American Indians

American Indian Nurses Association*

EXECUTIVE SUMMARY

The elders of the Indian Nations are living repositories of the cultural and spiritual values of the tribes. Traditionally, elders have been revered for what they represent and cared for by sons and daughters grateful for their knowledge. Within the last decade, however, increasing numbers of elders have been left alone as their children leave the reservations. Many are even victimized by those under the influence of alcohol.

In recognition of the special problems of the elders and in keeping with the philosophy of Indian Self-Determination, ideas are presented which tribes may elect to utilize in promoting quality long-term living for all Indian elderly. The long-term care continuum incorporates acute, sporadic, and continuous care provided in a multiplicity of settings ranging from the home and community through residential facilities. This concept addresses the individual/community/reservation/tribal identified needs of the well, frail, sick, and chronically ill.

Special attention is given to homemaker/home health, day care, and residential services. Discussion focuses on ways to provide a traditional cultural environment within these service delivery modes. For example, tribes can construct/renovate and operate nursing homes on the reservations which incorporate culturally-specific designs. Such elements could include rooms for family members to sleep overnight, room for a sing, room for the medicine man, traditional healing practices, and preferred foods.

One major thrust for long-term living is provision of a comprehensive education and training program for professionals, para-professionals, lay people, elderly, and non-elderly. Such a program would cover traditional beliefs and practices, the physiological and psychological processes of aging, physical care components, preparation for aging and retirement, and training in employment for elders (home health aides, foster grandparents, child day care, traditional counseling).

Tribes can initiate comprehensive community programs for their elders. There are three possible avenues to assist with assessment and planning. First, tribes can work through Federal agencies, such as Indian Health Service and the Bureau of Indian Affairs, to develop methodologies. Second, they can examine existing tools and modify them to be Indian-specific. Third, tribal planners can develop their own methodologies. Whatever option is chosen, a review of existing tools can facilitate discussion. Those presented include the Patient Appraisal, Care Planning, and Evaluation (Department of Health, Education and Welfare), the Patient Classification for Long-Term Care (Department of Health, Education and Welfare), the Genessee Survey of Inpatient Beds (Genessee Health Planning Council of New York), and the Quality Evaluation System (Department of Health, Education and Welfare).

* Contract 246-76-C-3241
231 South Peters, Norman, Oklahoma 73069.

INTRODUCTION

In anticipation of the Second National Indian Conference on Aging to be held in 1978, Indian Health Service contracted with the American Indian Nurses Association to prepare two technical papers on long-term care and environmental issues as they impact the Indian elderly. In order to achieve this objective, the American Indian Nurses Association convened a meeting of professionals, both Indian and non-Indian, to contribute their ideas. This meeting was held in Norman, Oklahoma, on February 10-11, 1978.

Upon completion of the initial drafts of both papers, the American Indian Nurses Association convened a second meeting, this one composed of Indian elders and potential consumers, in Albuquerque, New Mexico, on March 17-18, 1978. Participants reacted to the papers and presented their own ideas and recommendations. This paper incorporates content from both meetings.

For the purposes of this paper, "Indians" are defined as American Indians and Alaskan Natives who reside on tribal reservations or in rural/urban areas and are eligible for Federal and/or tribal programs.

PHILOSOPHICAL APPROACH TO PROVISION OF SERVICES TO ELDERS

American Indians occupy a unique position in the United States, being the only group of people who originated here. They have retained their tribal heritage. The tribe is a separate political, economic, social, and cultural entity. The reservation/village is a

storehouse of strength and culture of the American Indians/Alaskan Natives.

In recognition of this unique position, the United States Congress issued the "Indian Self-Determination and Education Assistance Act" in 1975. In Public Law 93-638, Congress acknowledged that

> the prolonged Federal domination of Indian service programs has served to retard rather than enhance the progress of Indian people and their communities by depriving Indians of the full opportunity to develop leadership skills crucial to the realization of self-government....

The Act further recognizes the right of self-determination and carries a commitment to involve Indians in planning, conducting, and administering programs.

Of crucial importance is the planning and implementation of programs to address the needs of the Indian elderly. Life expectancy has increased from 60 in 1950 to 65.1 in 1970. Based on service population data, Indian Health Service gives the following population estimates:

FY 1978		FY 1980	
Total	626,688	Total	668,128
45-54*	45,366	45-54	48,366
55-59	19,791	55-59	21,099
60+	53,976	60+	57,456
65+	37,557	65+	40,041
75+	13,423	75+	14,312
85+	3,390	85+	3,615

Source: Population Branch
Office of Program Statistics
Indian Health Service
October 12, 1977

These figures are acknowledged to be low by some 40,000.

The concern with the social, cultural, and psychological forces as they impinge upon the aging Native American in particular, although not of recent origin, is especially manifested in the scope and delivery of modern health care. If programs are to be implemented which meet the needs of Indian elderly, providers and administrators must recognize the uniqueness of the people with whom they are dealing. It is imperative that all organizations and agencies tie directly into the tribe's programs for meeting the needs of the elderly.

As with other health-related terms, long-term care implies a provider-patient relationship, with someone other than the consumer in control of the process. Therefore, it is imperative to stress that determination of need resides primarily with the individual and family in collaboration with the health provider. The goal is provision of services to address self-defined needs, not to arbitrarily force services, goods, or behaviors upon the client.

In this context, "living" can be substituted for "care," resulting in the "long-term living continuum." This simply means "living beyond one's own expectations and singular or familial capabilities" (Department of Health, Education, and Welfare, 1977:42). As people live longer, for example, their requirements for income, food, shelter, health care, and so on expand proportionately. In addition many individuals suffer from an increasing incidence of infirmities and illnesses throughout old age, necessitating health and medical interventions as well as assistance from family/community members. The provider's role, then, is to offer various facilitative, supportive, and treatment services to individual and family in expanding their ability to cope.

The ultimate goal is provision of quality living for all elderly Indians along a continuum of health and psychological needs. This concept addresses the individual/community/reservation/tribal identified needs of the well, frail, sick, and chronically ill.

LONG-TERM LIVING CONTINUUM

Traditional definitions of long-term care have proven inadequate. Definitions have focused on institutional care to the exclusion of preventive, ambulatory, and other service delivery modes. There is also disagreement over how to define the individual who requires long-term care. One alternative is to view long-term care needs as the totality of the individual's (and family's) response to a state of health, with the long-term care continuum incorporating acute, sporadic, and continuous care provided in a variety of settings to people of all ages.

This is reflected in the definition offered by the National Conference of Social Welfare (Department of Health, Education, and Welfare, 1977:3):

> Long-term care consists of those services designed to provide diagnostic, preventive, therapeutic, rehabilitative, supportive and maintenance services for individuals of all age groups who have chronic physical and/or mental impairments, in a variety of institutional and noninstitutional health care settings, including the home, with the goal of promoting the optimum level of physical, social, and psychological functioning.

In 1975, the National Center for Health Statistics sponsored a conference on long-term care data in Tucson. Conferees agreed on a broad definition of long-term care covering

ambulatory, domiciliary, and institutional

* Data collection increments as requested by the National Indian Council on Aging.

services for that growing segment of the population whose problems are of long duration and require assistance from the medical and related professions (Murnaghan, 1975:ix).

At the conference Rice and Waldman (Murnaghan, 1975) identified a broad range of services which they placed into three major categories:

I. Home Health Services (nursing and related, e.g., rehabilitation, social services) Nursing care, home health aide, medical care management.

II. Other Home Services (personal care) Homemaker, home maintenance, laundry, Meals-on-Wheels, social services, part-time caretaker, nutrition, transportation, activities of daily living, shopping.

III. Facilities
Day care, living (residential and institutional), foster/boarding homes, congregate care facilities, chronic disease hospitals, old age, convalescent centers, skilled nursing and intermediate care facilities.

Generally when people speak of the elderly in conjunction with long-term care, the picture evoked is the nursing home. However, according to the Division of Long-Term Care (Department of Health, Education and Welfare), only 5% of those over 65 years of age resided in institutions according to the 1970 census. As can be seen from the above three categories, the continuum of long-term care is composed of many more elements.

To help visualize the potential range of services from residential/institutional settings to home/community settings, the following list of options is presented. Individual tribes, for example, could review the range of services feasible as a guide to deciding what is appropriate to address their needs. The information is reproduced from the *Future of Long-Term Care in the United States* (Department of Health, Education and Welfare, 1977:4-6).

POTENTIAL RESOURCES AND SERVICES IN A CONTINUUM OF LONG-TERM CARE

Intramural

Definition: 24-hour residential services for long-term/intermittent/acute treatment.

- Federal hospitals (Veteran's Administration, Public Health Service)
- Chronic disease hospitals
- Psychiatric hospitals, county and state (adult/child)
- Psychiatric hospitals (nonprofit/proprietary; (adult/child)
- Training schools for developmentally disabled (e.g., blind, deaf, and mentally retarded)
- Special residential facilities for mentally retarded
- Residential special facilities for children (e.g., crippled children)
- Special facilities for aging (geriatric institutes, homes for elderly)
- Hospital extended care units
- General hospital special units (e.g., burns)
- General hospital medical and surgical units
- General hospital psychiatric units
- Skilled nursing homes
- Intermediate care facilities
- Personal care, shelter care, board and care homes
- Congregate living; group homes
- Intermediate alcohol and drug treatment units; detoxification units
- State and local forensic psychiatry units
- Detention centers; jail units
- Halfway houses and other special facilities for alcoholics and drug abusers
- Special living arrangements for the elderly (apartments, communities)
- Summer camps for disabled and handicapped

Intermediate

Definition: Nonresidential, less than 24 hours; person goes to agency or service locale.

- Information, screening, and referral services
- Crisis intervention
- Hospital emergency rooms
- Income maintenance and employment assistance, state and local social services
- Neighborhood health centers
- Senior citizen or geriatric centers
- Individual and group practitioners (health, mental health, social services, physical therapy, chiropractic, other)
- Health Maintenance Organizations (HMO's) outpatient diagnostic and treatment services
- Community mental health centers
- State and local social service agencies for counseling and related services
- Medical, dental, physical therapy and behavioral clinics (including universities)
- State and local public health departments
- Drop-In clinics
- Family planning clinics
- Local children's bureaus
- Sheltered workshops
- State and local vocational rehabilitation services
- Vocational education
- Employment counseling
- School special education classes
- Special day training schools
- Adult activity centers for mentally retarded and other handicapped
- Recreational-therapeutic activity programs for persons-at-risk
- Day camps for disabled

Day care centers (adult/child)
Night/day partial hospitalization

Extramural

Definition: Services are provided at the site of the problem, i.e., home, school and all of the facilities listed under Intramural and Intermediate. Services are provided by an individual worker or practitioner and/or agency personnel.

Spectrum of Extramural Services

House Calls

Medical	Crisis intervention
Psychological	Screening
Social work	Diagnostic/assessment
	Therapies
	Counseling

Home health visitations (nursing)
Home-delivered meals
Nutrition counseling
Personal care services
Homemaker services
Chore services
Shopping assistance
Income assistance and management counseling
Legal services and counseling
Vocational counseling
Employment counseling
Homebound teaching
Public library homebound services
Education TV programs for specific audience
Transportation services
Special support groups: Widow-to-Widow, Reach-to-Recovery, etc.
Friendly visitor
Telephone reassurance
(Traditional counseling)

Ideally, those in need of long-term care should be able to receive it in their own communities. However, the types of services needed to promote this are unclear. In the area of gerontology, most research has been basic rather than applied focusing, therefore, on such areas as etiology and factors leading to placement rather than alternative living arrangements (Department of Health, Education and Welfare, 1975).

Kraus et al (1976) attempted to discriminate between the institutionalized and the independent elderly. After observing the high rate of admission to long-term facilities and subsequent deterioration of many residents in Kingston, Ontario, they undertook a study of 193 institutional applicants versus 141 individuals living independently, all over sixty-five years of age. They interviewed the subjects and their relatives at varying points in time, and they found the following significant differences.

	INSTITUTIONALIZED APPLICANTS	INDEPENDENTS
Older; mean age 6.1 years higher		
Greater number of women		
Greater number living alone		
Lower monthly income		
Contact with and help from others less, but not to the degree of social isolation		
29% received help from community resources within past year; 19% still receiving it		1%
Substantial increase in reports of loneliness and depression		
Increased reports of poor health		
Cerebrovascular disease—17%		2%
More functional problems (bowel and bladder, sensory)		
Chronic disorders—81%		52%
Increased dependence with ADL*; Decreased mental functioning		
Participation in clubs, social activities—9%		45%
Those who reported just sitting around, 7 days a week—48%		14%

The Consumer Task Force offered many examples from their own experiences of the need of Indian elders to remain independent and in their own communities. They emphasized the need for elders to relate to the young. Such involvement is beneficial to both parties. The elders will be revitalized by the young, but they also have much to teach. As Brenwick (Consumer Task Force) emphasized, the elders have forgotten more than the young will ever know.

There were examples of elders who, as long as they could remain in familiar surroundings, could cope with life. Once institutionalized, however, these same individuals regressed.

Simmons (Consumer Task Force) related the experience of his grandmother who voiced her wish to die before she became too old, fearing that there would be no one to care for her and that she would be sent away to a home. With the elder, the wish is often equivalent to the action.

As opposed to the general population, American Indians/Native Alaskans do not fear death. For them it is simply a part of the continuum of life. Woodenlegs (Consumer Task Force) illustrated this with an analogy between growing old and the points on a compass. Birth represents the East. As the individual matures, s(he) moves slowly South, then West. Old age repre-

* ADL means: activities of daily living

sents the gradual swing North, then back to the East, the origin. For the elders, death is simply a return home and, if there is no longer a purpose to hold them among the living, they will take that journey back.

Nearly half of the factors in the Kraus study can be classified as psychosocial rather than medical. This is congruent with the growing trend acknowledging that appropriate care addresses physical (medical), social, psychological, and environmental requirements, and that this variety of needs must be reflected in a variety of services offered.

In this light, it is interesting to look at the ways other countries organize to deliver long-term care services. Such studies were undertaken by Kane & Kane (1976) and Carpenter (1976).

They report similar findings, including the replacement of the medical model with a socio-medical approach which focuses on the impact of illness on both patient and family. Both are included in the planning process.

In Sweden and Denmark, municipalities are legally responsible for locating and assisting elderly individuals in need of services. In Scotland, all citizens automatically receive letters from the Medical Officer of Health when they reach age sixty-five informing them of preventive and rehabilitative services available. A public health nurse makes a follow-up visit to answer any questions.

Multilevel institutional settings are established which offer housekeeping flats, old-age home beds, and long-term care beds. Communities provide sheltered flats and service houses. In Sweden, 2% of the space in new housing developments is designed for and allocated to the handicapped. Municipalities also contribute funds for modifying private homes to enable the old or disabled to continue living in them.

Another common mechanism enabling individuals to remain in their communities is the financial reimbursement of family members for services rendered (nursing, homemaking, meals, etc.). A number of short-term beds are reserved for such individuals should they or their families need a change of pace, vacation time, etc.

Retirement societies have been established in Israel. Individuals in their sixties are trained to help and support those still older.

In the United States, complexes providing different patterns of services similar to the modes described above are a relatively recent phenomenon, dating from the mid-1950's (Department of Health, Education and Welfare, 1975). One example of a multi-level institutional complex is the Philadelphia Geriatric Center, a campus housing over 1000 individuals. Skilled nursing and intermediate care facilities, high-rise apartments with maintenance services, small-unit community housing, general hospital, out-patient department services, and community outreach programs are provided. The Geriatric Research Institute conducts investigation into the biomedical, behavioral, and social aspects of the aging process. The Health, Education, and Welfare Region III Training Center for Long-Term Care is also located on the grounds. As might be surmised, the philosophy of the Philadelphia Geriatric Institute is that long-term care is a continuum with many options to match the diversity of needs, living arrangements, and service patterns found in the population (Liebowitz and Brody, 1975).

A program like the Philadelphia Geriatric Center, however, is still the exception, as reflected in an article by Doten (1976). Among the factors considered "innovative" among twelve programs are:

—individual living apartments with supportive services
—geriatric preventive dentistry
—reciprocal programs between elderly and youth
—community outreach via telephone hotline, daily telephone reassurance calls, bus service, Meals-on-Wheels
—educational programs for the patient, family, and community, with involvement of secondary school and college students

Because of the strong communal and family ties within Indian tribes, it is feasible that demonstration projects could be established on reservations/Indian communities incorporating the above elements as appropriate. High-rise apartment buildings, for example, could be architecturally redesigned in culture-appropriate models. For some tribes, living in proximity would be appropriate, but others would need greater distance and increased personal space. Pueblos, for example, choose to live in clusters, whereas Plains Indians prefer to live far apart. For the urban Indian, on the other hand, multilevel complexes offering a range of supportive services might be an approved alternative.

HOMEMAKER-HOME HEALTH SERVICES

As a group, American Indians lag behind the general population in economic and health status. Yet, because of their unique position vis-a-vis the Federal Government's responsibility to provide medical care through treaty rights, legislative, executive, and judicial actions, they have not always benefited by participation in health insurance plans open to the population at large (Primeaux and Banks, 1978).

However, with increased funds for and knowledge about services and organizational requirements, tribes are now in a position to sponsor more services in the home. Some have begun to develop formal home health agencies. When such tribal services and agen-

cies meet Medicare/Medicaid certification standards, the tribe can collect reimbursement for services provided to eligible clients.

As part of tribal and urban planning under P.L. 94-437, such services may well be addressed. At the same time, Indian Health Service has been authorized to collect from Medicare and Medicaid when providing home care to Indians eligible for Medicare and Medicaid. The difference between the tribally sponsored and operated services and those provided by Indian Health Service is how the funds collected can be used.

In the case of tribal sponsorship, the tribal agencies can use the Medicare/Medicaid funds in any way they wish. Indian Health Service, on the other hand, is mandated by law to use the funds to help its facilities attain and/or maintain accreditation standards. As Primeaux and Banks (1978) note, this combination offers Indian people greater options in planning for and choosing services and providers.

The extended family holds special importance in the Indian cultures. The success of the medicine man, for example, often lies in his ability to include the family and/or community in his approach to the health care of the individual (Primeaux and Banks, 1978). Indians believe that family involvement is integral to recovery.

Traditionally, the cultural expectation has been caring for the elderly in the home, not institutional placement. Combined homemaker-home health care programs, therefore, can accommodate the cultural expectations and practices of the Indian communities.

Homemaker Services*

Homemaker service is an organized community program provided through a public or voluntary non-profit agency. Qualified persons are employed, trained, and assigned to perform a full range of activities necessary to the maintenance of individuals or families in their own homes when long- or short-term illness, disability, psychosocial crises (or combination of these) require supportive, therapeutic or maintenance services to sustain independent living. The appropriate professional staff of the agency establishes the need for homemaker services, develops a suitable plan to meet it, assigns and supervises the homemaker-home health aides, and continually evaluates whether the service given meets the assessed need of its recipients:

1. Patient is homebound or can leave or be taken to needed services only with difficulty.
2. Patient requires only intermittent medical supervision and homemaker services to be maintained in his home.

* Definition provided by Bernice Harper (Provider Task Force)

Home Health

Regional hearings were held in 1976 to discuss the current status of home health care. Topics discussed here have been under scrutiny since then (Department of Health, Education and Welfare, 12/76; Comptroller General, 12/30/77). Major issues include the need:

1. to expand and coordinate a range of home health services
2. for greater third party coverage
3. for eligibility determined by assessment of client needs rather than by income/program eligibility requirements
4. to eliminate artificial barriers to access (three-day prior hospitalization, homebound, "skilled" care)
5. for quality assurance.

Under P.L. 95-142, Section 18, a one-year comprehensive study was mandated to examine ways to improve home health care. The completion date is October 25, 1978.*

Medicare (Title XVIII of Social Security Act) and Medicaid (Title XIX of Social Security Act) currently reimburse home health programs which are medically-oriented. According to Medicare regulations, for example, a home health agency is a public or private organization which furnishes skilled nursing and other therapeutic services. Services include (but are not limited to) part-time nursing care provided/supervised by a registered nurse, physical/occupational/speech therapy, and medical social services under a physician's direction. The agency bills for reimbursement after services are delivered to the client. Other sources of funding for home-based services can be obtained under Title XX of the Social Security Act (covered services vary according to the State), Titles III (grants for state and community programs to help individuals remain independent), IV (research and development projects), and VII (nutrition and socialization programs) of the Older Americans Act, and through the Public Health Service Home Health Development and Expansion activities.

Under P.L. 94-63, the Public Health Service provides project grant monies to develop home health care programs. Bills are currently before Congress (H.R. 10553, S. 2474) to extend funding beyond F.Y. 1978. Section 602a of the law provides money for development or expansion of home health services as defined under Medicare. Section 602b provides funds to train professionals/para-professionals employed in certified home health agencies. In awarding grant monies, preference is given to areas with a high

* See Appendix C for a list of Regional Office Contracts and key dates for 1978.

percentage of elderly and a medically indigent population.*

The American Indian Nurses Association (AINA), under contract with the Department of Labor, has developed a program for Home Health Aides in accordance with the philosophy of Indian Self-Determination. The association has worked with individual tribes to formulate needs, goals, and objectives of home health programs. Each tribe recruited a registered nurse (R.N.) from their communities to attend a course at AINA headquarters detailing the procedure for developing a Home Health Agency that would meet state and federal standards. The nurses were also prepared to teach tribal members the basic skills needed to become Home Health Aides. Elders were trained and employed through this program.

The tribes which participated now have Home Health training programs which offer training and employment opportunities to members plus the potential for developing agencies eligible for Medicare/Medicaid reimbursement. The following communities participated in demonstration projects:

1. All Indian Pueblo Council, Albuquerque (Laguna, Acoma, Canoncita)—Home Health Aide program with R.N. supervisor and 20 aides
2. Navajo (Gallup, Kayenta)—R.N. supervisor and 26 aides
3. Seminole Tribe (Hollywood, Big Cypress, Brighton)—R.N. supervisor and 18 aides
4. Cherokee Nation (Tahlequah, Oklahoma)—R.N. and 18 aides.
5. Choctaw Tribe (Durant, Oklahoma)—R.N. and 11 aides.

This represents 10 sites and 98 participants.

PLANNING FOR COMMUNITY CARE

Coordination can be achieved in the delivery of homemaker/home health/day care services by providing a variety of functions under the auspices of the tribe. This would include, for example, the client assessment and formulation of a plan, then monitoring status and making changes in the plan as appropriate. Other services to be provided could include an information network, referrals, and case-finding among the members of the tribe.

One problem commonly encountered is the lack of a methodology to determine needs. One way to begin to assess needs among tribal members would be to look at the number of individuals confined to their dwellings. Another would be to obtain the number of individuals served by Indian Health Service, Community Health Representatives, or other home health providers.

Another deterrent is the lack of a standardized assessment tool which could measure changes in the individual over time. One tool currently under development which has potential in this area is P.A.C.E., Patient Appraisal, Care Planning, and Evaluation (Department of Health, Education and Welfare).* Currently, it is being tested in skilled nursing and intermediate care facilities but will be expanded to include hospital and non-institutional delivery models such as home health. It could then function to such as home health. It could then function to promote continuity in care and planning as an individual moves from one health setting to another. In addition, it can serve as the original assessment tool when an individual first requires care. The entire form is filled out initially, then individual schedules are revised periodically according to individual needs. The basic outline of the tool is presented to provide an idea of the information involved.

Pace II Instrument

SECTION	BASIC PACE ITEMS
ADMISSION DATA	
Background Data	1. Facility Identification 2. Patient Identification 3. Date of Admission to Facility 4. Last Principal Provider 5. Date(s) of Prior Admission(s) to Facility 6. Date(s) of Prior Discharge(s) from Facility
Demographic Data	1. Date of Birth 2. Sex 3. Racial/Ethnic Background 5. Usual Occupation 6. Usual Residence 7. Usual Living Arrangement
Medical Data	A. Medically Defined Conditions Primary Diagnosis Secondary Diagnoses B. Medical Status Measurements 1. Height 2. Weight 3. Blood Pressure 4. Pulse Rate 5. Respiratory Rate 6. Blood Tests 7. Urine Tests 8. Stool Test for Occult Blood
DISCHARGE DATA	A. Discharge Date B. Status on Discharge C. Discharged To

* Interview with Mary Frances Hilton, March 6, 1977.

* As of June 26, 1978, this project was reported suspended.

PATIENT APPRAISAL DATA	PACE Appriaser Beginning Date of Appriasal i. Present Level of Care ii. Present Reimbursement Source(s) iii. Incidents/Accidents iv. Significant Change in Status Contributing Disciplines
I. Impairments	A. Skin 1. Decubitus ulcers 2. Other skin abnormalities B. Sensory/Communication Status 1. Sight 3. Expressive Communication 4. Receptive Communication C. Dental/Oral Status D. Bowel/Bladder Status 1. Bowel incontinence 2. Other bowel problems 3. Bladder incontinence 4. Other bladder problems E. Extremities and Trunk
II. Functional Status	A. Range of Motion 1. Lower Extremities 2. Upper Extremities 3. Head and Trunk B. Strength, Balance and Coordination C. Activities of Daily Living 1. Mobility 2. Personal Care D. Nutritional Status 1. Special diets 2. Intake problem 3. Output problem 4. Food likes and dislikes 5. Cultural/Religious Food Constraints 6. Supplementary nourishments 7. Usual dining location E. Psychosocial Factors 1. Patient/Resident's Adjustment to Care Plan 2. Patient/Resident's Social Interaction and Adjustment to Facility 3. Behavioral Problems
III. Patient Care	A. Special Procedures 1. General Nursing Care 2. Rehabilitative/Restorative 3. Teaching 4. Psychosocial B. Professional Visits C. Medications Drug Categories Drug Problems
IV. Readiness for Discharge	A. Functioning Status B. Service Needs C. Discharge within the month
DETAILED SCHEDULES	A. MEDICAL DATA B. SKIN C. PSYCHOSOCIAL FACTORS D. MEDICATIONS E. READINESS FOR DISCHARGE

Receipt of direct funding from the Federal government would enhance the tribe's capabilities for community programs. On February 28, 1978, Senator Domenici* introduced "direct funding" legislation, S. 2609, as an amendment to the "Older Americans Act." The Administration for Public Service, Division of Program Development (Department of Health, Education and Welfare), has received a proposal from groups in North and South Dakota for direct funding to the tribe from the Federal government.**

Provision of day care services is an important component of the long-term care continuum. Weiler et al (1976) estimated that institutionalization is inappropriate or detrimental for 20% to 25% of the long-term care population. They demonstrated the benefit of a day care model for elderly participants.

Trans-Century Corporation (1975) undertook a comparative study of adult day care, examining a sample of ten centers over a nine-year period. Two basic models emerged from the observed data.

Model I is characterized by a relatively high emphasis on health care with a correspondingly high percentage of professional staff. Many participants have had serious illnesses and require rehabilitation. On the average, 48% had some degree of paralysis, with many dependent in at least three activities of daily living.

Model II places greater emphasis on supervision and employs more non-professional staff. Participants tended to be less impaired, suffering more from infirmities associated with the aging process. Such programs are more socially-oriented and are multi-purpose compared to the primarily medical focus on Model I.

Day care† is a program of services provided under health leadership in an ambulatory care setting for adults who do not require 24-hour institutional care and yet, by virtue of physical and/or mental disability, are not capable of full-time independent living. The program is designed to meet a variety of care needs including health maintenance and restoration.

The essential elements of a day care service are

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* U.S. Senator Peter Domenici, New Mexico.

** Personal communication from Paula Brown, Program Analyst, March, 1978.

† Definition provided by Bernice Harper.

directed toward meeting the health care needs of participants. However, the socialization elements of the program are considered vital for overcoming the isolation so often associated with illness in the aged and disabled and in fostering and maintaining a maximum state of health and well-being.

1. Patient can come or be transported to day care center with reasonable amount of assistance.
2. Patient requires only intermittent medical and/or nursing supervision and the services provided within the day care center.
3. Patient may be under 65 years of age if other criteria are met.

Potential sources of funding for adult day care centers include Titles VI and XIX of the Social Security Act and Title IV of the Older Americans Act. The National Center for Health Services Research has funded demonstration projects under Section 222 of the Social Security Amendments of 1972 (Weissert, 1977). Two of the projects combine day care and homemaker-home health services. Although funding is no longer available for demonstration projects, tribes could consider incorporating these two elements of long-term care in a multiservice center.

The centers could run a variety of culture-specific programs and provide a place for the elders to teach tribal crafts, lore, language, etc., to the younger generations. Equally important for the urban Indian, such centers could provide a place for the elders to come together and interact in a familiar atmosphere where s(he) feels a sense of belonging and worth.

Daley (Consumer Task Force) spoke of the Albuquerque Indian Center, funded by the city, where urban elders can congregate, show their arts and crafts to each other, and share their time. Meals are served three days a week. Transportation is provided to pick up individuals and take them shopping and to various cultural events in towns, pueblos, and reservations. A nurse visits the center every other week to check blood pressures and provide diet counseling. Above all, the elders know they are not alone.

Daley emphasized the closeness and cooperation which exists among Pueblos, who are anxious to assist one another and share work. The center provides an avenue for elders to make others aware of their particular needs. Daley noted that they do many things for each other, including repair jobs and gathering wood. Provision of an adequate supply of wood is vitally important. Many elders prefer and still use their traditional wood-burning stoves.

Woodenlegs (Consumer Task Force), for example, described the difficulty the Northern Cheyenne have with maintaining enough wood to last through the Montana winters. Many elders freeze to death because they lack wood. As Woodenlegs phrased it, missionaries told Indians to "sit down, fold your hands, and then we forgot to do for ourselves."

The Mescalero Apaches have a Traditional Counseling Program in which elders teach crafts, games, dances, and other cultural activities, such as puberty rites, to young and old together. As Simmons (Consumer Task Force) emphasized, the tribe feels the need to preserve the culture as embodied by the elders, of whom so few remain. They are needed to instill cultural and spiritual pride in tribal members.

As played among Indians, for example, games differ from those of other cultural groups. Everyone plays together without artificial restrictions based on such characteristics as age, sex, and status.

Games are often characterized more by cooperation than competition. In the Indians equivalent of "football," for example, players (young and old, male and female) still scramble for the ball. However, the "queen of the game, chosen on the basis of her age and family position, can walk across the field to the goal line once she gets possession of the ball without anyone touching her.

Gambling is popular, but it is often done with possessions rather than with money. The individual knows that whatever s(he) loses this time may be won back the next time.

Games are often accompanied by special songs which the players chant in unison as they keep time to the rhythms. Playing a game is a community affair, with a place for everyone.

INSTITUTIONAL SETTINGS

The three major institutional settings currently recognized are skilled nursing facilities, intermediate care facilities, and mental health facilities. Some acute hospitals are considering converting unused acute beds to alternate levels of care, including intermittent and skilled care.

Whether as a result of severe, incapacitating illness/injury, lack of a home caretaker or unwillingness or inability of family to function in this role, special care needs, etc., there are individuals who require residential living for a short or prolonged period of time. A resident is defined as a patient or other individual who has been admitted to a care facility (including an institution for the mentally retarded or individuals with related conditions) and is receiving room, board and a planned program of care and supervision on a continuous 24-hour-a-day basis.

Skilled Nursing Facilities

These provide continuous nursing service on a 24-hour basis for convalescent patients, with an R.N. on duty at least eight hours a day five days a week in facilities approved as Medicare and Medicaid pro-

viders. Registered nurses, licensed practical nurses, nurse's aides, and orderlies provide a range of services. Emphasis is on nursing care with rehabilitative therapy, occupational therapy, and other health services as needed.

The skilled nursing facility is recognized as eligible for both the Medicare and Medicaid reimbursements, if the facility applies and meets certain conditions of participation, including that for staffing mentioned previously.

Intermediate Care

An intermediate care facility is an institution that provides health care and related services on a 24-hour basis at a level less intensive than that given in an acute care or skilled nursing facility. Medical, nursing, rehabilitative, and social services are provided as needed to assist patients in attaining or maintaining their maximum potential for independent living, whether within or outside the facility setting.

1. Patient needs health-related care and services on a 24-hour a day basis in an institutional facility that provides more than room and board but less than the level of care given in hospital or skilled nursing facility.
2. Patient requires intermittent medical, nursing, rehabilitative, social, and teaching services for the purpose of continuing or supervising the regimen established in the hospital or skilled nursing facility.

The physical well-being and the personal and emotional welfare of individuals in intermediate care facilities should be the prime concern of those who make determination as to the adequacy, appropriateness and timeliness of care and the treatment being rendered. Therefore, the intermediate care facility is designed to provide a protected environment for persons whose health needs require constructive supervision in an institutional setting to prevent deterioration and disability.

Supervision may be provided by either a registered nurse or licensed practical nurse. In the latter instance, an R.N. must be available for consultation at least four hours per week for a facility to be a qualified Medicare provider.

Mental Health Facility

A mental health facility is primarily engaged in providing diagnosis and treatment including psychiatric, medical, and nursing care; and other supportive therapies for persons with such things as various organic brain syndromes.

Institutionalization in any type of facility cited above deprives elders of the traditional position enjoyed in the tribal setting. Their contribution to the living lies in communicating the knowledge accumulated over many years. Simmons (Consumer Task Force) noted that sons and daughters have traditionally cared for their parents for the benefit of this knowledge. Within the last decade, however, there has been a rapid decline in the number of elders living with their families. Once they are sent away to nursing homes, the elders lose this purpose and die.

As younger family members move from the reservations into urban areas, more elderly are left alone. For some, home health care and homemaker services are not sufficient alternatives, and residential care is needed. This usually means geographical displacement to a nursing home miles away where the elderly will be placed among peoples of various ethnic backgrounds who are unfamiliar with Indian cultures and languages. This can result in severe emotional shock. It has been suggested that American Indians as a group suffer more anxiety and confusion when institutionalized than any other group (Forward Management Associates, 1977).

Members of the Consumer Task Force shared their own experiences with elders who retained some degree of independence and pride as long as they remained in their own homes. Once transferred to residential facilities, however, they regressed. Often they gave up communicating in English, speaking in their native tongues even when there was no staff member or other resident who could understand them. A recurrent theme of the task force, therefore, was the need to provide services for elders in their own communities, villages, and reservations.

One possible option was suggested by Askenette (Consumer Task Force). In Nevada in-home service workers visit the elders and assist with cleaning, medications, etc. During the winter when it is very cold, the elders are sent to institutional settings for their own protection. As soon as spring comes, however, they are returned to their own homes, and the workers begin visiting them again.

Brenwick (Consumer Task Force) drew an analogy between sending a child away to boarding school at age 5 and the elder to an institution at age 60. Askenette (Consumer Task Force) compared such placement to her experience as a child. She lived with her family in California until sent away to school in Nevada. Ten years passed before she saw her family again. In both case, the individual is suddenly thrust into an alien environment.

Facilities may not accept Indian elderly because they lack the staff capability (language, culture) to provide the necessary environment (FMA, 1977). Racism is still prevalent and may operate as a factor behind a decision not to accept elders.

Three nursing homes in the Phoenix Area highlight

the potential differences among facilities. One is located on the Gila Reservation; the other two are located in the suburbs.

The reservation home has a capacity of 76; 98% (about 74) are Indians. Out of 65 staff, 54% (about 35) are Indians.* Tribal membership, however, does not ensure quality care. Staff members must be highly competent and sensitive to the elders.

One suburban facility has a bed capacity of 140. Sixteen percent of the residents (about 22) are Indians. Out of 68 staff members, 6% (about 4) are Indians. The other has a capacity of 107, with 9% (about 10) Indian occupancy. Out of 52 staff, 10% (about 5) are Indians.

For some residents in the suburban facilities, their only communication in English consisted of the word "home." An effort is made to place tribal members together. For example, elderly Apaches are transferred to one particular nursing home if possible. Family members can then travel together from the reservation, a round-trip distance of 372 miles, in a bus rented by the tribe.

Placement planning such as this fosters the probability that the administration of the nursing home will plan specific cultural activities for the elders. It also gives the tribe some economic leverage when its members are grouped this way. The home with a 16% Indian population, for example, included two culturally-specific events for them in its outline of program activities for the month. One was a religious service provided by the Native American Church. The second included tribal songs and dances.

Harper (Department of Health, Education and Welfare, 1970) has examined the necessary ingredients for humanizing a (traditional) nursing home and maintaining optimal functioning (health, psychosocial) and well-being of residents. The focus is on the crisis aspect of such placement, the role of the family, and the need for cooperation and collaboration among all concerned. This is most useful in considering off-reservation placements. If, at some point, nursing homes are erected on reservations, the material is still appropriate for urban and other non-reservation Indians (e.g., Oklahoma Indians).

The initial recommendation for placement creates a crisis for the elder and his/her family. The individual needs help to prepare for the transition with a minimum of psychic trauma. This maximizes chances of using the experience positively. Family members need help in releasing the elder to a new living situation. Staff need assistance in understanding the person who is coming to live with them. One way to begin this process is through visits by nursing home staff to the elder, wherever he/she is located (home, hospital).

Each individual who comes to the nursing home is a human being with a history and life style: parent, homemaker, silversmith, potter, weaver, teacher, nurse, gardener, and much more. By focusing on each resident as an individual with a life history and addressing his/her needs accordingly, staff can provide a home away from home which will foster continued growth, development, and creativity in the individual. Staff and residents can then grow together and learn from one another.

RESERVATION NURSING HOMES

Given the geographic distances and cultural differences involved, tribes or their designated representatives should be encouraged to construct/renovate and operate nursing homes on reservations. The tribes can then arrange for culturally-specific building designs and construction, incorporating such elements as rooms for family members to sleep overnight, space for families to have a sing room for the medicine man, ideal number of residents per room, types of indoor recreational facilities, provision of outdoor recreation, etc. The tribes can incorporate whatever elements are needed to reproduce as closely as possible a traditional cultural environment (grooming, traditional healing practices, sweat baths, cultural and religious ceremonies, culturally-appropriate meals). Navajos, for example, could opt to build a circular facility with the door facing East in accordance with tribal practices.

The Mescalero Apaches have had a center for elders on the reservation close to the Public Health Service Hospital for nearly nine months. All the living units are electronically connected to the hospital. If an individual has trouble of any kind, s(he) can buzz hospital personnel for assistance.

Elders have been allowed to retain their traditional wood-burning stoves in the living units. Community members maintain the necessary supplies of wood for them. Apache is spoken in the facility. The tribe employs elders in the Traditional Counseling program and pays them for their services.

Both Brenwick and Simmons (Consumer Task Force) emphasized the difficulty that elders face when confronted with modern appliances. According to Simmons, one of the functions of community workers on the Mescalero reservation is to check the gas stoves in the newer homes. The strangeness of such an appliance has led to tragedy in the past, with elders becoming asphixiated or blowing up their homes when, without realizing the danger, some would light wood fires next to the stoves.

In the Ahtna Region of Copper Center, Alaska, a long-term care complex will soon be constructed with

* Figures provided by Dr. William Larsen.

various levels to serve people in need of services across all ages. It will be designed along the multipurpose center concept with a main lobby, nutritional center to serve traditional foods, and a range of supportive services.

As Woodenlegs (Consumer Task Force) emphasized, it is important to incorporate the traditional foods which native Americans have thrived on for years in such facilities.

> "Eat pemmican, chokecherry pudding, corn and hoof soup and be sure to drink plenty of Peppermint or Sarvis Berry tea." Those would be words good enough to make any of our Elderly well again, wouldn't it? Or how about Rose tea, wild turnips, wild carrots, ground corn mixed with grease as vegetables then have fresh or dried tripe, raw liver, raw kidney as meat for a heavier diet when the patient is gaining strength?

EDUCATION AND TRAINING

One major thrust for long-term living is provision of a comprehensive education and training program for professionals, para-professionals, and lay people, elderly and non-elderly. Training should be designed so that all administrators of services to the elderly, including family and tribal members, are involved from the planning stage through implementation and evaluation. The goal is to provide trained individuals, both elderly and non-elderly, to assist and work with the elderly of the American Indian population.

Such training has not been of high priority. With increasing life expectancy of the Indian population, adequately funded programs take on priority. This means providing funds and adequate planning to develop training programs, moving away from the crisis-generated response typical in many situations.

Many health care workers are non-Indian and do not understand the Indian culture as it relates to the total Indian being. Misinterpretation of behavior can result which leads to breakdown in communication and often alienation.

The tribes should be responsible for designing content and designating individuals to teach it. Each could produce, for example, a training manual for health workers, orienting them to such areas as specific healing beliefs and practices which differ from tribe to tribe. At the present time, such material is difficult to find in written form.

Health care providers can contribute their expertise in such areas as physiological and psychological processes of aging and the actual physical care components. Indian Health Service offers courses through the Office of Research and Development (ORD). The main ORD office, located in Tucson, Arizona, provides such courses as "Rehabilitation and Home Health Care" and "Maturity and Aging." Course components of the former include towel baths, transferring the client from bed to chair and in and out of a car, decubitus ulcer care, nutrition, diabetes, arthritis, and circulatory disturbances.

There are various field offices of ORD. One in Talihina, Oklahoma, trains community health representatives. The Black Hills Training Center in Rapid City, South Dakota, offers a variety of courses. The center at Santa Fe specializes in courses on food production, nutrition, and dietetics.

Training programs require an interfacing between native and non-native input. For example, principles of hygiene are important to the majority culture but may carry different significance for Indians. One needs to know the procedure for bathing the bed-confined individual. However, it is equally important to understand the cultural significance of the actions performed (see "Cultural Influences on Health Care").

The immediate family often lacks the skills to implement and render the services needed by the elderly member. The Navajo Nation pinpointed the neglect and inadequate home care of the elderly in their "Statement of the Needs of the Elderly in the Navajo Nation" presented at the 1976 National Indian Conference on Aging. They called for training of the children of the elders in such areas as provision of proper health care and purchasing and preparation of foods.

Training programs need to be established for family and tribal members in the developmental process of aging, caring for the elderly in the home, proper nutrition, etc. The tribes themselves can then establish on-going training programs with the appropriate content identified by the community members. Community people can administer the program and do the teaching, with help from experts as necessary. In this way, communities will build in local capabilities and expertise. Such a program would function for both Indian and non-Indian care-givers. Indian Health Service personnel, for example, could be assigned to participate in the training and orientation programs when first employed or when transferred from one area to another.

Another major thrust of training is directed at the elderly themselves, with the goal of training for long-term living. In Israel, for example, retirement societies have been established where individuals in their sixties are trained to support and work with those still older. The Navajo Nation, in the statement referred to above, recommended that the elderly be employed in day care centers for children, thus maintaining the tie between young and old. The Foster Grandparent Program is another viable option. The Older Americans Act makes provision for such a program

under ACTION, as well as for a Retired Senior Volunteer Program. The Department of Labor, under Manpower Administration, also provides for an Older Americans Community Service Employment Program. The elderly have a role to play as workers in schools, crafts centers, nutrition programs, etc.

Another area with educational implications is preparation for aging, retiring, and coping with stress and loneliness. Richard Chuculate (Consumer Task Force) emphasized this area particularly for the non-reservation Indian. Ideally, such preparation would begin early in the individual's life, thus emphasizing aging as another phase of the developmental process, having its own intrinsic rewards and potentials for continuing creativity and satisfactions.

CULTURAL INFLUENCES ON HEALTH CARE

It is imperative that health workers understand and accept cultural health practices. They must be willing, therefore, to talk with the individual and family about their beliefs and practices. Primeaux (1977) stresses the intimate relationship between Indian medicine and religion, noting that they are two faces of the same coin.

Illness is taken as a sign that the individual is out of harmony with nature, and the balance must be restored to effect a cure. One example of this is the sing. The Navajo sing brings together family members in a healing ceremony of ritual, chants, and sand paintings. Sings may last from half an hour in an institutional setting to 9 days in the community setting (Primeaux, 1977).

Bergman (1973) compares a major sing to open-heart surgery, noting that the medicine man is called upon to perform from 50 to 100 hours of ritual chanting, myth telling, and sand painting, all without error. Concurrently the singer must manage a large and difficult group process involving the relatives and friends of the patient.

The health worker needs to be aware of tribal healing rituals. These may involve the use of foods sacred to the particular tribe. Cornmeal, for example, is considered curative by some tribes and may be sprinkled on the floor in a nursing home or on the shoulder of a community health worker entering the home. Cedar is another important substance. Some burn it in religious/healing rituals, others carry it in medicine bags.

Among the Northern Cheyenne, medicine arrows are sacred. They are stored in a special place accessible only to the tribal healers. The symbolic representation of the medicine arrows can only be worn by certain members of the tribe.

In some tribes traditional medicine can incorporate one or more of the following in healing rituals (Ackerknecht, 1971): purification of medicine man and patient; singing and rattling; smoking a holy pipe; application of a drug; suction; application of a tea; gentle massage, small sacrifice; eating.

An item possessing curative powers may be hung on the individual's body or close to the bed. It is imperative that such items not be removed or disturbed.

Bathing and grooming of the elderly need special consideration. Modesty is important. It is always advisable to ask permission to give the bath and ascertain who the most appropriate person is to assist with the bath (sex, age, family member, staff person of a nursing home, community health representative, etc.). Special attention needs to be given to appropriate disposal of hair, nail clippings, etc. "Appropriate" means giving these items back to the family to handle. Navajos, for example, would want hair found in their combs properly taken care of, not just discarded (Kniep-Hardy and Burkhardt, 1977). The Consumer Task Force provided instances where community workers, ignorant of these practices, threw hair into the fire with other sweepings and found themselves barred from homes afterward.

Another important area is that of obtaining a history of consent from the client for specific treatments and procedures. Respect for individual rights is strong. Among the Navajo, for example, no one has the right to speak for another (Kniep-Hardy and Burkhardt, 1977). The health worker must keep this in mind when dealing with the elder and other family members. Rather than trying to obtain information/consent from another, the family member may be utilized more appropriately in helping to explain the purpose of the information to the client. Time must also be allowed for family consultation.

The concept of time among American Indians/Native Alaskans is radically different from that of the Anglo culture. Indians live in the present, not the future. "Time is on a continuum with no beginning and no end... Indian time is casual and is relative to what needs to be accomplished." (Primeaux, 1977:93). Understanding the difference has implications in many cases, including setting up health care appointments and the timing of medications.

The elderly account for 10% of the general population but use 25% of the drugs prescribed. (Basen, 1977). In prescribing drugs for the elderly Indian, it is critical to understand both Indian and Anglo medicine. Indians made a large contribution to European medicine in the area of medicinal herbs. It is important for medicine man and physician to work together to assure that the Indian elder is not taking a potentially harmful combination of drugs. Bergman (1973) emphasizes this need for cooperation and collaboration, noting that he often referred patients to

medicine men while practicing among the Navajo, and vice/versa.

Medication routines may also be affected. Navajos, for example, usually take traditional medicines in large quantities for a limited time. This has teaching implications in that one pill prescribed four times a day is not interchangeable with four pills taken once a day. Woodenlegs, (Consumer Task Force), for example, noted that one problem with medication among the Northern Cheyenne is the tendency to take too much at one time.

Understanding attitudes toward death and dying is important in working with the elderr and their families. Death is accepted as another part of the life cycle. It is important to understand death rituals and taboos, which are vastly different among tribes.

Among the Osage, for example, it is important for the living to touch the dead. This removes any ill feelings that may have existed while the individual lived and is their way to say goodby. For the Navajo, on the other hand, it is taboo to touch the dead.

Among the Ahtna, no member of the immediate family is allowed to touch the dead, be a pallbearer, or help dig the grave. With the Osage, the immediate family is expected to perform all such functions for the dead.

Another important consideration is the definition of "immediate family." Kinship ties differ among tribes. Therefore, this definition also changes from tribe to tribe.

Once the health worker is familiar with the beliefs and practices of a particular tribe, s(he) can plan interventions accordingly, taking cues from the family as to who shall perform which services for the dead. Maxine Chuculate (Consumer Task Force), for example, related an experience of hers as a nurse at Pine Ridge, South Dakota. When one male patient died, she and another nurse found themselves in the position of having to lift the body when male relatives refused. It was taboo for them to touch the body.

For some tribes, such as the Ahtna, an open display of emotion is encouraged whereas for others, such as the Shawnee, it is considered inappropriate. Brenwick (Consumer Task Force) discussed the potlatch which follows a death among the Ahtna, where everyone comes together and feasts. The grieving family is encouraged to cry openly. The coffin is covered with a new, white Hudson Bay blanket. Possessions are divided and given as gifts to honored guests, so chosen by some aspect of their relationship to the dead. Brenwick gave the example of the potlatch following the death of a young woman who had been ill for some time. As an honored guest, her parents invited a pilot who had flown the woman hundreds of miles to the hospital for treatment.

Sensitivity to these factors is equally important when working with Indians who enter the health professions. Otherwise cultural beliefs of both health care provider and consumer may inadvertently become barriers.

LONG-TERM CARE NEEDS ASSESSMENT, PLANNING, AND EVALUATION

There are a lack of planning methodologies, guidelines, and manuals available in a practical and useful format that could assist tribal planners in assessing their long-term care needs. Therefore, there is a need to develop planning methodologies that can be used by the tribes to document their long-term needs.

There are three avenues open to the tribes to assist in assessment and planning. First, they can work through Indian Health Service, the Bureau of Indian Affairs, and other Federal agencies to develop methodologies. Second, they can examine existing tools (e.g., P.A.C.E.) and modify them to be Indian-specific. Third, tribal planners can develop their own methodologies.

The first step in program planning is a means of identifying individuals currently or potentially in need of services. Examples are given on page 11 describing how countries such as Sweden and Scotland handle this. Each tribe can initiate a community-wide survey of individuals from forty-five on, making rosters and interviewing each to have the individuals identify their own needs. This in conjunction with professional assessment will help the tribe identify the resources needed to meet these needs and monitor the progress of its members. If tribes elect to use the second approach, a review of existing tools is useful.

The literature available on planning covers determination of bed needs, patient and service classifications, and cost analysis across a variety of settings. One study of bed needs for inpatient settings is the *Survey of the Need for Inpatient Beds in Monroe County 1974-1975*, by the Genessee Health Planning Council of New York.

Because a sizable proportion of patients are misplaced in the beds they occupy, the Genessee planners designed a methodology to sort patients according to medical needs rather than the kinds of beds occupied. In this way they hoped to correct for placement errors and arrive at more realistic estimates of the need for beds.

One nurse and one physician, working independently of each other, conducted surveys in the following types of facilities: hospitals, nursing homes and skilled nursing facilities, health related or intermediate care facilities, private proprietary homes for adults, local state mental hygiene facilities, and individuals at

home who were prospective candidates for long-term care. With one exception, samples were generated by a table of random numbers, with sample size per facility determined by number of beds per facility.

Medical indications, broadly defined to include physical, functional, psychological, and mental statuses, constituted the primary basis for placement evaluations, with social factors secondary. When a survey team judged a particular patient to be misplaced, a staff member of that particular facility was consulted for agreement/disagreement.

Because of the difficulties in a single assessment of psychiatric patients by an outsider, two modifications were made in the survey of mental hygiene facilities. First, the attending (multidisciplinary) staff prepared a summary for each sample patient which the survey team used to supplement their observations. Second, each patient judged suitable for community placement was also evaluated by the intake personnel of the appropriate referral facility.

The subjects in the home category were obtained as a result of fliers and notices distributed to county doctors, community groups, bank, pharmacies, grocery stores, churches, the Department of Social Services, the Visiting Nurses' Service, the Health Department, and libraries. Announcements were made over radio and television. Over 1,000 names were collected over a 2-month period.

The percentages of persons judged to need each level of care (see chart on pp. 110) in the five surveys (excluding that of the mental hygiene facilities) were applied to the maximum load of each facility type determined over a twelve-month period (thirteen months for the hospitals). The estimates arrived at were then adjusted according to acceptable occupancy rates at the time, 90% for hospitals and 95% for long-term care facilities (percentages have since changed). This figure was adjusted a second time by the predicted population growth between 1975 and 1980. The new figure was adjusted a third time by the acceptable occupancy rate to arrive at the final estimate.

One major advantage of this methodology is the focus on actual patient needs regardless of current levels of care. Because the Genessee planners have repeated the surveys every three to four years, physicians, nurses, and other health care providers have had the opportunity to arrive at definitions and criteria for the levels of care which are clear and precise. This is a prerequisite to evaluating appropriate placement.

The methodology is weak as a planning tool for non-institutional services. Estimates for day care and home health care, for example, cannot be generated from the collected data.

Because the estimates are predicated upon peak occupancy, there may be periods when these are inflated. This has to be balanced, however, by the potential for a shortage of beds in relation to actual needs. The surveys are intermittent. Therefore, there is always the potential for data to lag behind actual needs.

The following chart synthesizes the information collected on the study sample in the 1974-1975 Genessee Health Planning Council's survey of beds among various facilities. General characteristics of each group are provided on the left, with a corresponding description of those individuals who were judged to be placed inappropriately on the right. The box on the right also shows recommended dispositions for these same individuals. The sorting methodology is based on actual need rather than type of bed occupied.

RESULTS OF THE GENESSEE SORTING METHODOLOGY

Type of Facility	*Sample Characteristics*	*Number Judged Inappropriately Placed*	*Agreement or Disagreement*	*Characteristics of Those Inappropriate Judged*
Hospitals medical-surgical intensive care coronary care rehabilitation medical-surgical self-care unit	Sample of 189 (10.9% of total) Age range: 16-94 (mean of 58.8) Women: 59.3% Men: 40.7% Length of stay: 1-74 days (mean of 10.5) Some degree of mental impairment: 24.5% Judged appropriate: 93.1%	13 or 6.9% (decrease from 27% in the 1969-1970 survey)	101% agreement	Age range: 36-94 10 individuals over age 65 Number judged appropriate for: SNF 11 (5.9%) ICF 1 (0.5%) PPHA 1 (0.5%) Length of stay: 6-38 days
Skilled nursing facility (SNF)/nursing home	Sample of 302 (8.7% of total) Age range: 20-103 (mean of 80.7) Women: 76.8% Men: 32.2% Length of stay: 1 day-18 yrs., 10 months (mean of 2 years, 1 month) Some degree of mental impairment: 83.4% Judged appropriate: 90.4%	29 or 9.6% (47.9% in the 1969-1970 survey)	Disagreement on 1 case	Age range: 55-93 Number judged appropriate for: ICF 27 (8.9%) PPHA 2 (0.7%) Length of stay: 30 days-18 years, 10 months
Intermediate care facility (ICF)/health related facilities	Sample of 157 (12.4% of total) Age range: 27-96 (mean of 77.9%) Women: 66.2% Men: 33.8% Length of stay: 1 day-18 yrs. 7 months (mean of 2 years, 4½ months) Some degree of mental impairment: 50% Judged appropriate: 65%	55 or 35% (23.4% in 1969-1970	Disagreement on 1 case	Age range: 51-94 Number judged PPHA 54 (34.4%) Own Home 1 (0.6%)
Private Proprietary Homes for Adults (PPHA)	Sample of 189 (17% of total) Age Range: 31-94 (mean of 74) Women: 66.7% Men: 33.3% Length of stay: 2 days-15 yrs., 21 days (mean of 1 year, 7 months) Some degree of mental impairment: 39.7% Judged appropriate: 55.6%	84 or 44.4% (35.9% in 1969-1970 survey)	Not given	Age range: 44-93 Number judged appropriate for: SNF 1 (0.5%) ICF 83 (43.9%) 1 month, 2 days-15 years, 21 days
At home	Sample of 202 (29.9% of total) Age range: 29-94 (mean of of 75.5%-based on data for only 146 subjects) Women: 78.1% Men: 21.9%	Not given	Not given	Number judged appropriate for: Acute 1 (0.5%) SNF 20 (9.9%) ICF 18 (8.9%) PPHA 5 (2.5%) Home Health 40 (58.4%) All Other 118 (58.4%) (psychiatric care, Meals-on-Wheels, home, refused to participate; deceased, etc.)

PATIENT DATA SYSTEMS

In 1975 the National Center for Health Statistics sponsored a conference on long-term care data in Tucson. Work was begun on the development of a long-term care minimum data set which would provide a common methodology for acquiring data on the long-term care client for multiple providers across a range of settings.

In 1976 the United States National Committee on Vital and Health Statistics convened a technical consultant panel, chaired by Dr. Ethel Shanas of the University of Illinois, to continue work on the development and refinement of this data set.

Although the final form has not yet been achieved, the following outline provides the content of the March, 1978, draft version of the long-term care minimum data set.*

LIST OF ITEMS IN THE LONG-TERM CARE MINIMUM DATA SET

Demographic Items

1. Personal Identification
2. Sex
3. Birth Date
4. Race/Ethnicity
   - A. Race
   - B. Ethnicity
5. Marital Status
6. Usual Living Arrangements
   - A. Type
   - B. Location
7. Court Ordered Constraints
   - A. Court Ordered Care
   - B. Court Appointed Guardian

Health Status Items

8. Vision
9. Hearing
10. Communication
    - A. Expressive Communication
    - B. Receptive Communication
11. Basic Activities of Daily Living
    - A. Bathes or Showers
    - B. Dresses
    - C. Uses Toilet
    - D. Transfer In and Out of Bed or Chair
    - E. Urinary or Bowel Incontinence
    - F. Eats
    - G. Walks
12. Mobility
13. Adaptive Tasks
14. Disruptive Behavior
15. Orientation-Memory
16. Disturbance of Mood
17. Primary and Other Diagnoses

Service and Administrative Items

18. Provider Identification
    - A. Type
    - B. Unique Number
    - C. Location
19. Last Principal Provider
20. Date of Admission/Entry/Active Service
21. Date of Discharge/Termination
22. Direct Services
23. Disposition of Patient/Client
24. Principal Source of Payment for Services
25. Charges for Services

Procedural Items

Date of Report.

A major classification tool developed within the past few years is the **Patient Classification for Long-Term Care** (Jones, 1974; Denson and Jones, 1976; Falcone and Bright, 1976).

This is the product of the work of four research groups from Case Western Reserve, Harvard, Johns Hopkins, and Syracuse Universities. The tool provides a uniform terminology to describe patient needs and is useful in planning, evaluation, research and resource allocation.

The goal of the research group was to devise an assessment procedure which met five criteria (Densen and Jones, 1976:127):

1. Focus on the patient: The classification must describe the individual as he/she is at a specific point in time as well as show changes which occur over time.
2. Multidimensional descriptors: Again, medical diagnosis alone is insufficient. The tool must, therefore, describe the individual in terms of functioning, impairments, risk status, socio-demographic status, etc.
3. Use of objective rather than subjective/interpretive statements: In order to meet this requirement, the tool must provide the information upon which determinations for prognoses/judgements are to be made.
4. Relevance to classification: Items to be included should be chosen on the basis of scientific/epidemiological evidence demonstrating a relationship between item and patient outcome.
5. Flexibility: The tool must meet the needs of diverse users. This translates into incorporation of successive levels for each item, ranging from the broadest categorization to increasingly detailed ones.

The classification tool which the research group arrived at is contained in the 1974 publication men-

* Information provided by Joan Van Nostrand.

tioned above. In 1976 a companion tool was produced for potential users entitled *Patient Assessment: A Training Manual for Use of Patient Classification in Long-Term Care.** It explains the procedure for completing the form and describes how to use the information for preadmission screening, developing care plans, medical evaluation, pharmaceutical review, utilization review, and discharge planning. As with P.A.C.E., the tool would have to be modified and made culturally-specific.

Lensen and Jones (1975) report on the testing of the tool among patients with different needs and prognoses. It also indicated whether or not there was progress toward treatment goals. Nurses found the forms so useful in summarizing and providing information that they incorporated them into patient charts.

Members of the Harvard group (Harvard Center for Community Health and Medical Care), working under contract with the Department of Health, Education and Welfare, produced a patient assessment system incorporating the descriptors in the above publication along with items describing services and additional psychosocial information (Flacone and Bright, 1976). The actual form is four pages long. Assessments on each individual are recorded at four different times. The major categories with examples of items included are:

Demographic Data	Summary of admission, discharges
	Education
	Occupation
	Usual living arrangements
	Discharge planning
Functioning Status Items	Mobility level
	Walking
	Bathing
	Dressing
	Bowel and bladder functioning
	Eating
	Behavior pattern
	Communication of needs
	Orientation (time, place, person)
Impairment Items	Sight
	Speech
	Dentition
Medically Defined Conditions	
Risk Factor Measurements	Blood Pressure
	Height
	Weight
	Lab tests
Therapies	
Medications	
Nutrition	
Special Nursing Procedures	Eye care
	Dressings
	Decubitus ulcers
	Teaching self-care
Psychosocial	Visitors
	Recreation/activities
	Religious services

Another tool, developed by Mitchell and Sumner (1976) to identify, analyze, and compare costs across a range of services is the *Methodology for Finding, Classifying, and Comparing Costs for Service in Long-Term Care Settings*. A team composed of nurse and financial analyst used the following instruments: site-visit procedures summary, data collection protocol for patient data, and data collection protocol for cost and care-giver service data. This enabled the researchers to profile patients, classify services, and identify costs. Problems identified during this phase were documented, presented to the panel, and the tool revised as necessary. Phase II plans call for testing the methodology in eleven alternative care settings in 29 states, with the goal of developing a planning methodology for use at the federal, state, and local levels.

This methodology is a promising planning tool incorporating classification of patients and services and cost-finding across a variety of settings in one package. Unlike the **Patient Classification for Long-Term Care**, the focus is not primarily institutional. Definitions are clearly spelled out.

QUALITY EVALUATION

Two instruments focus primarily on evaluating quality of life and care, P.A.C.E. (described on pp. 101-102) and Q.E.S. (Quality Evaluation System). The Q.E.S. methodology was originally devised by Rush-Presbyterian-St. Luke's Medical Center and Medicus Systems Corporation. Refinement of the methodology continued in a study conducted by Medicus and the Illinois Department of Health under contract with the Division of Long-Term Care, DHEW. This phase ran from July 1, 1974 to July 31, 1976, and involved testing in 150 Illinois facilities. Q.E.S. provides an example of matching methodology which incorporates institution- patient-centered elements.

The program is computer-compatible (COBAL) and has three system components. First, there is a set of survey instruments and procedures for resident reviews and facility surveys. Second, there is a construct relating measures of quality in a three-level hierarchy (facility, resident, matching). Third, there is a com-

* DHEW Publication No. HRA 75-3197, 11/74.

puter system for processing survey data, determining scores at each level of the construct, and generating facility and resident profiles. Two nurse surveyors collected the data, usually over a period of three person-days. Multiple sources were used to assure reliability and validity: direct observation, staff interviews, self-administered facility administrator's questionnaire, a 10% resident sample, and medical records.

WAVE I tested 100 facilities from 1972 to 1974. Items which failed to cluster with others to form a scale or which did not discriminate between high and low quality were dropped from the WAVE II form. Iterative use of Q.E.S. with increasingly larger samples enabled the researchers to refine a tool of over 3,000 items down to 127 in the shortest version, the abbreviated survey form. The WAVE II instrument was tested in 1,350 residents in 65 facilities from November, 1975 to January, 1976.

During WAVE II testing, an experimental design was used with a panel of experts for content validity. Comparison between Q.E.S. assessments and those of the panel showed significance at .85.

WAVE II disclosed other findings. Q.E.E. can be used by a State in certification activities. Neither federal nor state (Illinois) laws prohibit this use. Where federal certification noted major deficiencies in facilities, Q.E.S. did also, rating such settings in the bottom 30%. Q.E.S. detected one deficient facility previously passed by federal certification. The follow-up questionnaire to facility administrators showed that a majority preferred Q.E.S. to federal procedures. The methodology is cost-effective, involving approximately the same expense as the federal procedures.

In addition Q.E.S. is not biased toward one profession but is capable of multidisciplinary assessment. It presents a methodology for incentive reimbursement.

One problem with the use of this methodology is that it is currently limited to a specific population, the institutionalized elderly. This is reflected in the definition used by the researchers (*Q.E.S.*, 1976:1.11): "quality long-term care is that care which predisposes the elderly (or other) individual to achieve his or her highest feasible level of physical, social and psychological functioning." They do recommend further refinements of Q.E.S. including use in non-institutional settings, for the mentally retarded and developmentally disabled, and development of matching on a service to need basis for use in placement decisions.

MECHANISMS FOR CONSUMER INVOLVEMENT

There is a network of Indian Health Boards for other American Indians to utilize. This is composed of local (Service Unit) health boards which elect tribal representatives to Area health boards which, in turn, send representatives to the National Indian Health Board headquartered in Denver, Colorado. These Boards have an advocacy role and also participate in planning and evaluating health programs operated by IHS.

The National Indian Council on Aging, elected by tribal groups at the first National Indian Conference on Aging, is both an advocacy and an action group on behalf of the special concerns of the Indian elderly. At some point, consideration might be given to the establishment of an Indian gerontology research center. Such a facility could provide three services:

—a clearinghouse for information and documentation of issues concerning the quality of life of the elder

—technical supports in program implementation, operation, and evaluation

—consulting assistance on aspects of aging, program planning and evaluation.

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The Reverend Pinezaddleby (Consumer Task Force) emphasized the contributions of American Indians to the cultural and spiritual values of their country. These values are embodied in the elders. One dominant theme expressed by the Consumer Task Force as a group is the urgent need to preserve the small number of elders who remain as the repositories of the Indian cultures. Woodenlegs (Consumer Task Force) summarized this theme:

> Last, but not least, promote the Elderly in every way to encourage the younger set to gain respect for them, their lives, their heritage, interest, wisdom, culture, abilities and their great devotion of the Great Spirit. Only then will young people be able to look forward to good health, long life and good things for Indian people. And to bear witness when they get old to the greatness of God through gratitude for all things taught to them when they were young.

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GLOSSARY

American Indian—American Indian/Alaskan Native is defined as one who is eligible for Federal and/or tribal programs and resides on a tribal reservation or in a rural or urban area of the United States.

Home Health Agency—Under the Social Security Act, Section 1861(o), a home health agency means a public agency or private organization, or a subdivision of such an agency or organization, which—

(1) is primarily engaged in providing skilled nursing services and other therapeutic services;

(2) has policies, established by a group of professional personnel (associated with the agency or organization), including one or more physicians and one or more registered professional nurses, to govern the services (referred to in paragraph (1) which it provides, and provides for supervision of such services by a physician or registered professional nurse;

(3) maintains clinical records on all patients;

(4) in the case of an agency or organization in any State in which State or applicable local law provides for the licensing of agencies or organizations of this nature, (A) is licensed pursuant to such law, or (B) is approved, by the agency of such State or locality responsible for licensing agencies or organizations of this nature, as meeting the standards established for such licensing;

(6) meets such other conditions of participation as the Secretary may find necessary in the interest of the health and safety of individuals who are furnished services by such agency or organization;

Except that such term shall not include a private organization which is not a nonprofit organization exempt from Federal income taxation under section 501 of the Internal Revenue Code of 1954 (or a subdivision of such organization) unless it is licensed pursuant to state law and it meets such additional standards and requirements as may be prescribed in regulations; and except that for purposes of part A such term shall not include any agency or organization which is primarily for the care and treatment of mental diseases.

Home Health Aide: An individual trained to deliver supportive services, under the supervision of a registered nurse which are required to maintain normal physical and emotional comfort and to assist clients toward independent living in a safe environment. Such services include hygiene (bathing, care of mouth, skin, hair), assistance with ambulation, help with prescribed exercises, help in relearning household skills, assistance with eating and meal preparation, and assistance with self-administered oral medications.

Homemaker Services: these services provide for the overall management of a home during a family member's illness. Services include assistance in personal care, help in maintaining a safe and healthy environment, assistance to the client in carrying out the treatment plan, and evaluation by agency staff to determine changes in client's condition or family situation which might affect the plan for home care.

Indian Health Service Population: Members of federally recognized tribes who are eligible for direct and contract services.

Intermediate Care Facility: Under the Medical Assistance Program an ICF is defined as an institution licensed under State law to provide health-related care and services to individuals who do not need the degree of care provided in a skilled nursing facility but, because of their physical/mental condition, do require services (above room and board) which can only be provided in an institutional setting. Health services supervision is provided seven days a week eight hours a day. This supervision may be provided by either a registered nurse or a licensed practical nurse. In the latter case, a registered nurse must be available for consultation four hours a week.

Medicare: Medicare is a Federally administered health insurance program under Title XVIII of the Social Security Act which helps persons 65 years of age and older, and many severely disabled persons under 65 years of age, to pay the high cost of health care. The program includes Part A-Hospital Insurance, and Part B-Medical Insurance. Hospital Insurance (Part A) helps pay for inpatient hospital care and for certain follow-up care outside the hospital. Medical Insurance (Part B) pays for doctors' services and many other medical items not covered under hospital insurance.

Medicaid: Medicaid is a state-administered assistance program jointly paid for by the participating states and the Federal government. Medicaid is available in all states except Arizona. The State Medicaid Agencies are required by law—Title XIX of the Social Security Act—to provide a number of basic health services for all people receiving Federal financial assistance. Basic health services may also be provided to persons eligible for medical, but not financial assistance. The basic services include inpatient hospital care, outpatient hospital services, other laboratory and X-ray services, skilled nursing facility services and home health services for persons over 21 years of age, family planning services, and physician services. Early and periodic screening diagnosis, and treatment for persons under 21 years of age must also be included.

Proprietary agencies: Private agencies operated on a profit-making basis.

Skilled Nursing Facility: Under the Medical Assistance Program an SNF provides services ordered and supervised by a physician which can only be provided on an inpatient basis. The institution must be certified under State and Federal standards. A registered nurse must be on duty seven days a week, eight hours a day, with 24-hour nursing services provided. In areas with personnel shortages, such a facility may be allowed to operate with a registered nurse on duty only five days a week, eight hours a day.

Traditional Counseling: Employment of elders by the tribe for the express purpose of teaching younger members the traditional ways of life and cultural values of the tribe (myths, legends, rites and rituals, games, music, dances).

APPENDIX A

A. SUMMARY OF LEGISLATION AND REGULATIONS IMPACTING ON SERVICES FOR THE AGING

Legislation	*Coverage*	*Eligibility*	*Providers*	*Regulation*
Title XVIII of the Social Security Act (Medicare.	Under Section *1812*, program payment can be made for visits to homebound beneficiaries under a physician's plan of treatment for part-time or intermittent nursing care, physical, occupational, or speech therapy, medical social services, part-time or intermittent services of a home-health aide, medical supplies, medical appliances, and outpatient services arranged by a home-health agency and a hospital, skilled nursing facility, or rehabilitation center. Under *Section 1812 (a) (3)* up to 100 part A visits per BENEFIT PERIOD CAN be made, but beneficiary must have been an in-patient in a hospital for at least 3 days or have received covered services in a skilled nursing facility for a period not exceeding 1 year from the date the home health plan is is implemented. *Section 1832(a) (1) (A)* provides for 100 Part B visits per calendar year and is related to a *Section 1835 (a) (2) (A)* requirement similar to the Part A benefit.	Part A *Requirements* 1. Age 65 or disabled. 2. 3 day stay in participating hospital. 3. For further treatment of condition treated in hospital or SNF. 4. Need for part-time skilled nursing, physical therapy or speech therapy. 5. Homebound 6. Physician determines need for care and establishes plan of treatment within 14 days after discharge from hospital or SNF. Part B *Requirements* 1. Age 65 or disabled. 2. Need for part-time skilled nursing care, physical therapy, or speech therapy. 3. Physician determines need and establishes plan of of treatment. 4. Homebound 5. Home Health Agency participating in Medicare.	Home Health Agencies must be in compliance with Federal, State and local laws. Conditions of participation range from the type of services (e.g. an HHA must include part-time intermittent skilled nursing services and one other specific service), to administration and professional personnel requirements.	Subpart L—Regu-#5-Conditions of Participation Part A. Intermediary Manual, Section 3120-3129.

Legislation	*Coverage*	*Eligibility*	*Providers*	*Regulation*
Title XIX of the Social Security Act (Medicaid).	Under *Section 1905 (a) (7)* Home Health care services are mandated.	All "categorically" needy individuals over age 21, all "categorically needy" individuals under 21, *if* the States cover them for skilled nursing facility care; and all "medically needy" individuals eligible for skilled nursing facility services.	Home Health Agencies must be Medicare certified or be medical rehabilitation centers meeting the standards in the regulations.	45CFR 249.10(b) (7) (III) defines the required services as: nursing services, home health aides, and medical supplies, equipment, and appliances; and *may* make available: physical therapy, occupational therapy and speech pathology/hearing therapy.
Title XX of the Social Security Act (Social Services).	No section of the legislation mandates inclusion of home health services.	All "categorically" needy eligible individuals plus Medicaid eligible, and income eligible.	Social Service agencies at the State and local level.	Regulations do not require any specific home health service to be included in the State plan but at least one type of Home-Based Service is included in all State plans, and Home-Based Services may include a wide array of services such as Homemakers, Chore Services Home Health Aide, and Home Management
Title III and VII of the Older Americans Act of 1965.	Under the Area Planning and Social Services (Title III) allotment to the States, home services must be one of four priorities.	Title III-No set age limits are established under these provisions of the Act, however, the Act generally applies to the age group of 60 plus. Title VII-Those persons who are aged 60 and over and their spouses regardless of age are eligible to participate in the Title VII programs.	Each State Agency on Aging must divide entire State into planning and service areas and designate Area Agencies on Aging for Coordination of services. There are presently 521 Area Agencies covering 90% of the Nation's persons aged 60 and over.	Title III-45CFR Part 90 Grants for State and Community Program on Aging. Title VII-45CFR Part 90 Nutrition Program for the Elderly.

Source: *HOME HEALTH CARE*
Department of Health, Education and Welfare
December, 1976
pp. 56-58

B. CHECKLIST OF SERVICES ACCORDING TO LEGISLATION

Type of Service	*Title XVIII*	*Title XIX*	*Title XX*	*Titles III & VII Older Americans Act*
Nursing Care	X	X		
Home health aide/homemaker	X	X	X	X
Chore service			X	X
Shopping assistance			X	X
Home delivered meals			X	X
Transportation			X	X
Checking				X
Social and recreational				X
Housing				
Administrative/legal				
Food, groceries				X
Personal care				X
Continuous supervision			X	

C. REGIONAL PROGRAM CONSULTANTS FOR HOME HEALTH: APRIL 1978

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* First number in each entry is Federal Telecommunications System Network. The second is the commercial telephone number.

Dates for 1978:
July 1—Training Grant Applications Due
September—Award of Training Grants

D. ONAP* URBAN INDIAN STRATEGY

A. *Urban Indian Center Criteria:*

To be eligible for funding, an Indian Center must meet the following structural criteria:

1. The application Indian Center must be an established agency which has:
   a. Articles of incorporation and bylaws (corporate structure) or an ongoing formalized organizational structure with a constitution and bylaws.
   b. A present economy or means of support. It should have some experience in the budgeting and control of funds.
   c. A governing Board whose membership is at least 51% Indian and which has been publicly elected by the Indian community which the Center is established to serve.
   d. A building or address from which to operate.
2. The Indian Center must be a multi-purpose organization which has the potential of offering a range of services in order to meet basic human needs.
3. The Indian Center must have the capacity for servicing at least 200 people. At present, only Centers located in cities with an Indian population of 1,000 or more are eligible. This figure is an in-city figure, not an SMSA figure. (All population figures must be approved by ONAP Central Office.) Population will be determined by one of three ways:
   a. the 1970 Census
   b. another Federal agency's figure for an in-city population
   c. a survey conducted by an acceptable methodology

B. *Grantee Responsibilities*

A grantee must perform the following activities:

1. Conduct a needs assessment of the population to be served.
2. Identify existing service delivery systems and methods by which the Center can link up with such systems.
3. Perform outreach and referral activities for the Indian community members. This includes the tracking of persons served or referred and undertaking the necessary follow-up activities.
4. Develop a planning and evaluation system.
5. Mobilize various resources consistent with community needs. Duplication of mainstream services should only occur in areas of barriers to service.

C. *ONAP Funding Policies*

1. Monies transferred from Central Office ONAP to the Regions must be used to fund only those grantees which meet the structural criteria outlined in Part A and only for purposes consistent with ONAP's urban strategy as specified in this paper. Any deviations from this must first receive Central Office approval.
2. Eligible cities will be funded on a formula guideline basis. The guideline figure is arrived at by multiplying the in-city Indian population by $42. This guideline is to serve as the maximum amount allowable and is applicable not only with respect to on-going funding levels but also to one-time-only supplementals (other than those awarded from carry-over balance money.
3. No urban grantee may be funded at a level below $30,000 or above $200,000, irrespective of the Guideline level.
4. Indian organizations are to be funded directly. Any other arrangements such as funding an Indian organization as a delegate agency to a general-purpose government will not be approved unless such arrangement has the prior written consent of the Indian Center in question.
5. ONAP dollars may not be used for the direct provision of services. Rather they are to be used for core administrative purposes. This includes but is by no means limited to such activities as paying the salary of an Executive Director, a planner, an outreach worker or a fiscal officer responsible for the overall Center's budgetary matters. ONAP dollars might also be utilized to assist in the payment of a Center's rent, utilities and basic equipment and/or supplies.
6. Only one multi-purpose Indian Center may be funded per city.

For further information, contact Administration for Native Americans, DHEW, 300 Independence Avenue, S.W. Washington, D.C. 20201

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* ONAP (Office of Native American Programs) has been renamed. It is now Administration for Native Americans.

APPENDIX C

Physical and Mental Health of Elderly American Indians

Association of American Indian Physicians, Inc. *

CHAPTER I

PREFACE

Background

The following technical papers on the physical and mental health of the aging American Indian were developed by the Association of American Indian Physicians, Inc. (AAIP), at the request of the Indian Health Service (IHS). Initial contact with AAIP was made by IHS in October, 1977, to determine the organization's interest in preparing the papers. A contract (IHS Contract No. 246-78-C-6001) was subsequently negotiated, and became effective October 17, 1977, to extend through March 31, 1978.

On November 5, 1978, the AAIP Board of Directors selected chairmen for two task forces to prepare the papers: Gerald Ignace, M.D., (Physical Health) and Everett R. Rhoades, M.D., (Mental Health). A planning meeting of the two chairmen, the AAIP Executive Director, and H.C. Townsley, M.D. was held November 16, 1977, to select members and resource persons for the two task forces, and to choose a consultant. Using a list of names provided AAIP by the National Indian Council on Aging, Inc. (NICOA) and the Indian Health Service at a meeting in Oklahoma City, Oklahoma, on the same date, the process was begun. Approximately 30 persons whose names were suggested could not be contacted. Of the remaining 12, none were available to participate due to the short notice. (It was planned to have a meeting of the two task forces December 15, 1977, in order that data collection be begun and plans made for development of the papers).

A consultant, Melody J. Marshall, Ph.D. was hired December 1, 1977. The first meeting of the members of the two task forces and resource persons was held December 15, 1977, in Albuquerque, New Mexico. At this time plans were outlined for the development of the papers. A second meeting of these persons was held April 15, 1978, to review the first draft. Members of the Physical Health Task Force met in Oklahoma City, May 10, to review the revised draft copy of the physical health paper. Members of the Mental Health Task Force met at the AAIP office May 20 and 21, 1978.

The AAIP Executive Director, William Wilson, attended the NICOA Planning meeting on February 16-17, 1978, in Tucson, Arizona, for its Second Annual Conference, at which time he provided an update on the status of the two papers, and received input from that group.

Due to the extreme short period of the initial contract (5 months), which included planning, data collection and analysis, and writing, two one-month extensions were provided, making May 31, 1978, the end of the contract period, at which time AAIP was to provide IHS with a final report.

The ideal manner in which to prepare the papers would have been to have conducted independent studies regarding the physical and mental health of various groups of Indian elderly. The brief time period made this option impossible. Thus, already existing statistics related to IHS and contract outpatient visit and hospital discharge diagnoses were used. The use and limitations of such data are discussed in Chapter IV.

Definition of Aging

For the purpose of these papers, aging is defined as: "The progressive changes which take place in a cell, tissue, organ system, total organism, or a group of organisms with the passage of time. All living things change with time in both structure and function, and the changes which follow a general trend constitute aging" (Shock, 1957).

Aging affects the individual physically, socially, and emotionally. It is the interrelationship of the changes which occur in these three areas and the capacity of the person to successfully adapt to the environment that promotes desirable health in the later years.

The reader may wish to refer to the unpublished manuscript developed by the IHS Committee on Aging, "Indian Health Service: A Health Profile of the Aging and Aged Service Population with a Report on Related Activities."

We have attempted to stress the importance of cultural requirements in all discussions and hope we have prepared this paper from an Indian perspective. For those who wish to read further, we have supplied pertinent references.

Glossary of Terms

A glossary of terms is included in this report for the reader's edification; this appears in Appendix B.

Case Studies

Appendix A contains case studies of selected Indian elderly in nursing homes.

* Contract #246-78-C-6001
6801 South Western, Suite 206, Oklahoma City, Okla. 73139.

Acknowledgements

Acknowledgement is made and appreciation extended to several persons who contributed data and material for the papers, including Mozart Spector, Director, IHS Office of Program Statistics, and his staff who provided the statistical information regarding morbidity diagnoses and causes of death. The section on the health of urban Indian elderly was written by Dorothy Miller, DSW, Institute of Scientific Analysis, Panorama City, California, and Carolyn Attneave, Ph.D., Department of Psychology, University of Washington. Kelly M. West, M.D., Professor of Biostatistics and Epidemiology and Clinical Professor of Medicine, University of Oklahoma Health Sciences Center, developed the chapter on diabetes in American Indians. The case studies of Indian elderly were developed by William Larsen, M.D., Phoenix Indian Medical Center.

Consumer input during the development of these papers was provided by Cecilia Blanchard (Kickapoo) and Rev. Bob Pinezaddleby (Kiowa).

Mrs. Joe Bales Graber, Director, Office of Health Resources, and Miss Rosemary Wood, Chief, Nursing Branch, Indian Health Service Headquarters, served as co-project officers for this contract.

Finally, thanks are given to the members of the two task forces and resource persons who assisted in the development of the documents.

The information contained in the documents reflect conclusions of the authors, and do not necessarily represent the opinions of the Indian Health Service, Association of American Indian Physicians, the National Indian Council on Aging, or the Indian people.

CHAPTER II

EXECUTIVE SUMMARY

Introduction

These papers on the physical and mental health of the aging American Indian by the Association of American Indian Physicians were developed at the request of the Indian Health Service. Due to the extremely brief contract period (7 months), it was impossible to conduct appropriate in-depth, independent research. Consequently, IHS data related to APC visits* and hospital discharge diagnoses, Mental Health Branch information, and causes of death as listed on death certificates were analyzed. In addition, 27 urban Indian programs were contacted for identification of the health needs of that segment of the Indian population. Specific limitations of the use of such data are discussed in the chapter on methodology.

The preponderance of younger persons in the IHS service population, when compared with the U.S. population, may be seen in Figure 1. In fact, 53% of persons who seek care from IHS and contract facilities are under 20 years of age; 76.77% are younger than 40 years.

* APC refers to ambulatory patient care visits to hospital outpatient departments and clinics.

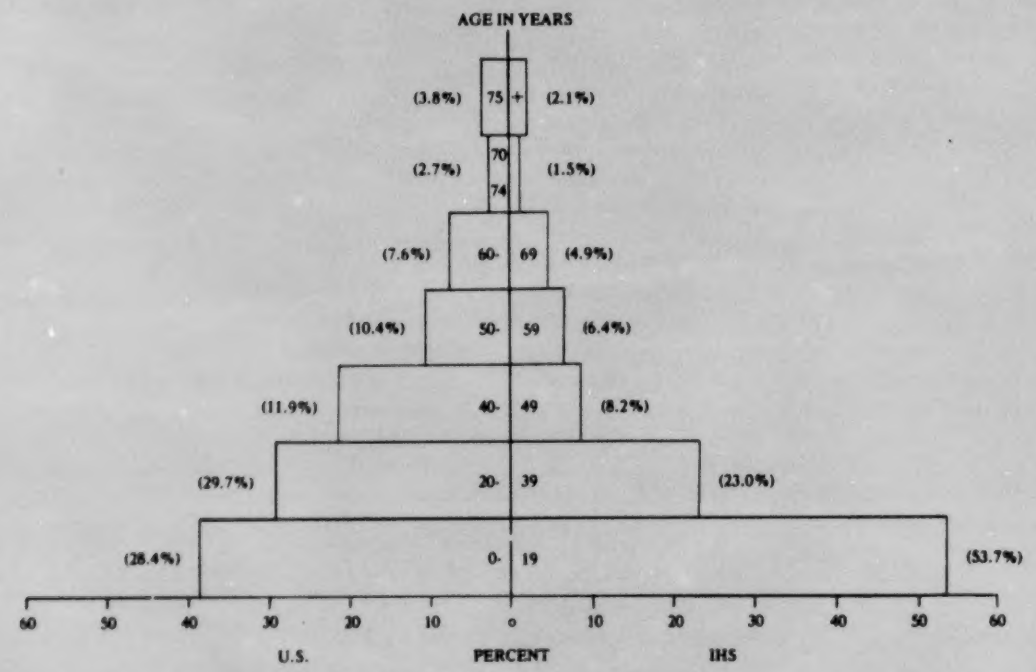

Figure 1. Percent of IHS Service (1975) and U.S. (1970) Populations by Age

Discussion

Elderly Indians do not necessarily have unique health problems when compared to what is known about non-Indian elderly. There are, however, certain attributes of Indians, not necessarily restricted to the elderly, which demand specific attention.

For example, perhaps the most devastating, pervasive abnormality is obesity. This is not only already of epidemic proportions, but indeed seems to be relentlessly increasing. We have shown that this condition is an extremely important associated factor or precursor of many diseases. These include several types of cardiovascular and cerebrovascular diseases, gall bladder disease, and diabetes. It appears that the Indian community is generally aware of this problem and its importance, but strikingly absent are any programs designed to attack the problem of obesity.

Although there are indeed a lot of data, the way in which they are collected presently is open to considerable error. Only very crude estimates are permissible. With this in mind, it appears that certain inferences can be drawn. It seems justifiable to conclude that there is a problem with "mental health" of the elderly Indian. The extent and impact of this problem, and the factors relating to it cannot yet be precisely defined. What is most noticeable is that the magnitude of the problem in the elderly is only a fraction of the problem among the young adult and middle-aged, at least as measured by the number of visits recorded in the present systems. The pattern of visits compared to the number of persons presenting for treatment in different age groups, however, raises fundamental questions demanding further investigation. For example, one needs to know whether a lower utilization of facilities by the aged means that they harbor fewer mental health problems than do younger persons or whether there are selective barriers to treatment.

An example of a problem which appears to diminish with age is alcoholism. The rates of visits for severe conditions, such as schizophrenia, as estimated from the scanty data, do not appear to differ greatly from the rest of the population in the United States. There is, however, a suggestion that manic-depressive psychosis may be less common among Indians than among non-Indians.

Although a great deal is known about the mental health needs of the elderly Indian, a great amount of information is needed. Little systematic data regarding Indian mental health has been collected. In the past few years there has been a dramatic turnaround in attention to mental health problems witnessed by the rapid growth of the mental health program of the IHS.

Appropriate research would include the development of culture-specific testing instruments for Indian communities; the collection of data that would permit comparisons between Indian elderly and non-Indian elderly; research into factors which place people in positions of high risk for the development of mental disorders; and preventive programs. Because the problems are complex and because they arise from a variety of factors, a comprehensive multi-disciplined approach is needed.

The members of the task forces on the physical and mental health of the aging American Indian are impressed by the prevalence of cataracts and other problems affecting vision. These obviously are of major importance for the elderly; again the absence of targeted programs protecting the vision of the elderly is impressive.

Similarly, the importance of adequate dentition for aging Indians must now be addressed. No new knowledge or technology is needed for this, simply a rearrangement of priorities.

We are struck by the fact that, for most categories, the preponderance of APC visits occuring in Indians is found among those 20 to 55 years. This is true for many conditions, even when the data are corrected for proportions of population representation. This is perhaps most true of mental health problems, but also undoubtedly applies to many physical conditions, i.e. obesity and hypertension.

From a strict disease orientation, the three most prevalent physical conditions among the elderly are diabetes, pneumonia, and cardiovascular disease. It is widely accepted that poor nutrition poses a problem for all elderly. The importance of nutrition to overall good health is not always recognized.

Based upon the APC data, it would appear that the prevalence of rheumatoid arthritis may be greater among older Indians than the U.S. elderly as a whole. There are no comparable data for this latter group that would permit any comparison of our findings in this regard.

Information regarding the destruction of the American Indian family as related to the elderly is glaringly absent. What does appear in the literature pertains particularly to children and young adults. The impact of this phenomenon on the aged is worthy of study.

In this analysis we have identified areas in which program emphasis related to Indian elderly might be placed based on an analysis of IHS data. The next chapter will consider recommendations for service delivery, research, disease prevention, and data collection.

CHAPTER III

RECOMMENDATIONS

The following recommendations of the members of the task forces on the physical and mental health of

the aging American Indian are made in light of an analysis of IHS data related to use of health services, death certificate information, and felt needs or urban Indians. They are separated into 4 categories: those related to health services, disease prevention, data collection, and research.

Health Services

1) *Develop an interdisciplinary team in each Area that would have expertise in the field of geriatrics.*

This team might contain a physician, nurse, social worker, nutritionist, clinical psychologist, dentist, and physical therapist. These persons would serve as resource persons to health workers in the various service units in the field of aging and help to develop specific programs directed toward the health needs of Indian elderly. Particular attention should be given to cooperative efforts with programs in the larger community which relate to aging, as well as to the incorporation of traditional medicine approaches.

It might also be well, at some time in the future, to give consideration to the development of a Geriatric Branch in the central IHS office, keeping in mind that aging is only one part of the life cycle. This type of organization should not be accomplished to the exclusion or at the expense of younger population groups and in such a manner which precludes program modifications as the health needs of Indians change.

2) *Examine and improve the logistics of getting the elderly to health services.*

This might include employing drivers who would transport older Indians and free the CHRs to concentrate on helping elderly meet their social and health needs.

3) *Refine the program of continuity of care for the elderly.*

More specifically, this would make provisions for increased ease with which the elderly move from home to hospital to home.

4) *Strengthen the emergency medical care system.*

The provision of quality emergency medical services is particularly crucial for persons with selected diseases, i.e. acute myocardial infarction. More Indian lives might be saved as a result of the implementation of this recommendation.

5) *Develop optical screening and hearing testing programs.*

This should include the provision of eyeglasses and hearing aids when indicated.

6) *Increased emphasis on ambulatory care programs, such as the establishment of geriatric ambulatory care.*

Also included in this recommendation is the use of physician extenders, i.e. nurse practitioners and physician assistants, for the conduct of chronic disease clinics. It is generally accepted that these individuals can monitor stabilized chronic illness, thus freeing the physician to devote time to those persons requiring his or her professional expertise.

7) *Emphasis in all programs should be given to the preservation and incorporation of traditional and cultural modes, such as the use of traditional foods, etc.*

This recommendation is self-explanatory and needs no further elaboration.

8) *Develop specific programs to improve the nutrition of all Indians, including the elderly.*

Added emphasis on nutrition programs, including nutrition education, would help in the prevention of obesity as well as improve the general health status of Indians. Since diet is important in the treatment of numerous diseases, including diabetes and cardiovascular diseases, the implementation of this recommendation would have a therapeutic as well as preventive effect on Indian health.

9) *Develop programs to alleviate the problem of obesity.*

Obesity is probably the single, overriding physical health problem of Indians. The determination of the etiology of this condition for various Indian groups, with resulting programs to attack it, would be of great importance.

10) *Conduct a needs assessment of dental problems of Indian elderly, followed by implementation of appropriate preventive and treatment programs.*

This recommendation includes the provision of dentures and other dental prostheses, when indicated. The less than optimal nutritional status of many Indian elderly may be due to the inability to eat some foods because of poor dentition.

11) *Develop programs targeted toward early detection and treatment of hypertension.*

High blood pressure appears to be a significant problem for Indians, even in relatively young age groups. Since this condition is a contributing factor to other illnesses, i.e. acute myocardial infarction and cerebrovascular disease, it would seem that additional emphasis should be placed in this area.

12) *Establish cataract removal as a priority for the elderly.*

We have noted the relatively high prevalence of cataracts in older Indians. The only treatment for this at the present time is surgical removal.

Disease Prevention

1) *Strengthen existing and develop additional programs aimed at preventing selected diseases and conditions which appear to have the greatest impact on American Indians, including the elderly.*

Several conditions are identified in the health service

recommendations which have implications for preventive programs, i.e. hypertension, obesity, and dental health. Preventive efforts could have a significant impact on health and be conducted at less cost than the actual treatment of these conditions once they have developed.

2) *Develop and implement a comprehensive and coordinated program of health education at the service unit level in all Areas.*

Health professionals tend to assume that lay persons have positive attitudes toward and are knowledgeable about their health, when, in fact, most are relatively ignorant about their bodies and how they function. Health education efforts should receive a high priority in order to involve the individual in his own health maintenance.

3) *Implementation of pneumonia vaccine program.*

Our data analysis has shown that pneumonia is a significant problem for older Indians, especially those over the age of 74 years. A pneumonia vaccine program could change this pattern.

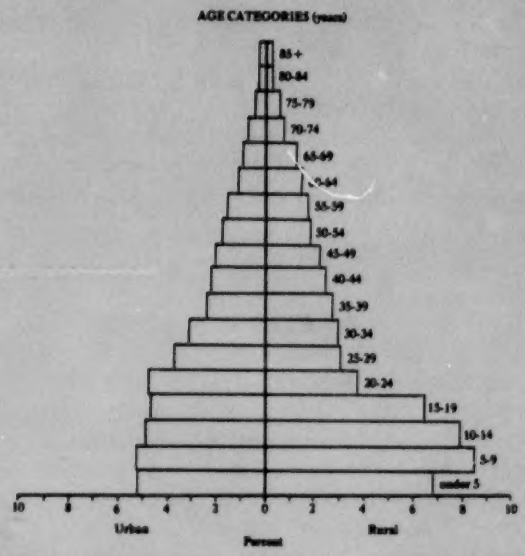

Figure 2. The Age Distribution of American Indians according to urban or rural residence. (1970 Census).

Data Collection

1) *Accumulate statistical data in a manner consistent with other Governmental agencies.*

Different Governmental agencies collect and analyze statistical data in various ways, using different age groups, terminology, and codes. This recommendation is made in order to facilitate comparisons between population groups.

2) *Record data related to APC visits and hospital discharge diagnoses in a similar manner.*

For example, APC visit statistics are coded for chronic bronchitis/emphysema, and respiratory allergy, asthma and hay fever. Hospital discharge diagnoses data are grouped as bronchitis, emphysema, and asthma. Thus the diagnostic categories are dissimilar and comparisons are impossible.

3) *Develop methodology for data collection and coding that would allow for computation of "true" incidence and prevalence rather than "treated" incidence and prevalence.*

The rationale for this recommendation appears in the methodology chapter of this paper.

4) *Give emphasis to the collection of urban Indian health data.*

Approximately ½ of Indian population resides in urban areas. (Figure 2).

Little health data has been collected on this segment of the population. The American Indian Health Care Association has begun accumulating such data. We feel that this activity should be continued and receive emphasis. The manner in which this is carried out should allow for comparison with that collected by IHS.

Research

1) *Investigation to determine reasons for variations in use rates of various facilities between Areas and different age groups.*

We have noted these differences in this report. It would be helpful to know the reasons for them in order to facilitate planning for health services.

2) *The conduct of focused longitudinal studies related to selected disease conditions should be accomplished.*

These studies would be of particular value when done in the areas of alcoholism and suicide, relating these to age. The findings would contribute to a better understanding of the patterns of pathology and point to means of prevention of their occurrance.

3) *Develop culture-specific methods of assessment and testing, particularly in the area of mental health.*

This would allow for a more precise evaluation of psychopathology among Indians.

4) *The Indian family.*

Emphasis should be placed on understanding the changing nature of the family, including its effect on Indian elderly.

5) *Perceptions of health professionals toward the elderly.*

An individual's perception influences the manner in which he or she relates to and works with another. It is generally accepted that many health professionals do not like to work with older individuals. Recognition of this would assist in the staffing of health facilities so that those who do enjoy providing services to the elderly are assigned to do so.

6) *Cause and nature of particular disease conditions among Indians.*

These studies would be very appropriate for hypertension and obesity trends.

It is not intended that these recommendations be exhaustive. Rather these are the major ones which we feel are most obvious as a result of our data analysis.

CHAPTER IV

METHODOLOGY

The conduct of research related to the health of various population groups requires a considerable period of time. In some instances, the planning phase alone may consume 6-9 months before any data collection is begun. The present study on the physical and mental health of the aging American Indian was completed in a brief 7 months. This does not mean that the observations, conclusions, and recommendations are invalid. It does, however, preclude the gathering of independent study data and restricts the analysis to readily available statistics.

This report draws upon different data sources and presents analyses of several different kinds. In order to obviate confusion for the reader, we shall describe some orienting terms.

Data Sources

Indian Health Service Ambulatory Patient Care Data (APC Data)

Service units constitute the actual locus of delivery of direct services within the Indian Health Service. Indians may receive health care in an IHS outpatient clinic or from a contract facility. Data related to these ambulatory care visits, including visit diagnoses, are coded and entered into the IHS computer. Searching through the recorded list of diagnoses for all medical contacts, therefore, one can analyze the visits of patients with various physical and psychiatric diagnoses.

Hospital Discharge Diagnoses Data

Another group of data that may be used as indicators of the health of a population are hospital discharge diagnoses. These reflect those conditions for which persons need to be hospitalized and may have more significance for some illnesses than for others. For example, persons with the diagnosis of acute myocardial infarction are routinely hospitalized. Once the individual is discharged the diagnosis, for purposes of followup in the ambulatory care setting, is changed to chronic ischemic heart disease.

IHS Mental Health Branch Data

In 1974, the IHS Mental Health and Social Services Branches instituted an automated record-keeping system. For each contact made, data concerning a client's age, sex, and primary and secondary problems are recorded. These data differ from those described in the section related to APC data in that persons have now become clients of the mental health or social service branches; many of them will be persons who have been referred through the ambulatory care medical facilities and will thus overlap with those in the APC data. Others may have been referred from other sources. Thus, the overlap is incomplete. Data from the mental health branch only have been used for this report. It should be noted that, when patients are described in this system, they are described by means of presenting problems, not by formal diagnoses, as in the case of data described in the APC data section.

Causes of Death

Mortality information is usually obtained from death certificates. Causes of death are important data to analyze when looking at the health of a population as they also are indicators of major health problems.

Urban Indian Data

Data related to health of urban Indians are presently dependent upon scattered surveys containing relatively small samples. Consequently, it is impossible to present a comprehensive picture of this segment of the Indian population. Although the American Indian Health Care Association is beginning to accumulate such information, it will be some time before these data will be available. For this reason, 27 urban Indian centers and clinics were contacted and asked to provide information related to the health problems of Indians whom they serve. Ten (37.04%) responded. These data are shown in Table 13, Chapter VI.

Data Analysis

APC Visits

The IHS APC data are recorded as patient visits. Obviously, this is not the same thing as counting patients and interpretations of these data must be made with caution. For example, more refined analyses suggest that a young or middle-aged adult contacting a facility has a greater chance of making repeated visits than a very young or an elderly person, regardless of diagnosis (Beiser and Attneave, 1977). Consequently, the data represent **visits** and not individuals. If one were to assume that number of visits corresponded roughly to the number of patients, this could lead to serious misinterpretations.

In addition, several disease conditions, i.e. hypertensive disease, may necessitate more APC visits than

other conditions, such as allergies/asthma/hay fever, or influenza. Recognizing that different illnesses require differences in frequency of visits helps to keep the data in perspective.

Other Data Limitations

Certain other limitations of these data deserve mention. Several factors contribute to an inability to readily compare the visit and discharge diagnoses to the health of the U.S. population as a whole. Various Government agencies tend to record health data differently. Documents published by the U.S. Bureau of Health Statistics contain few disease categories. Furthermore, the age categories presented are very broad and do not lend themselves to adequate comparison with IHS population groups for which the categories are classified in a different way.

It must also be kept in mind that the information gathered is only as valid as that recorded on the patient's record. For example, it is possible that one physician may see a patient and record one diagnosis. Another physician may see the same person but record the diagnosis differently. Secondly, the individual who codes and records the diagnosis for statistical purposes may do so in a manner which fails to coincide with that of another recorder.

Just as with morbidity statistics, certain facts must be remembered when interpreting mortality figures. It is possible that the primary cause of death listed on the death certificate may fail to reflect the true immediate cause of death. For example, the cause of death may be listed as "chronic alcoholism" rather than the true physical cause, "cirrhosis of the liver." Despite this potential flaw in reporting, death certificates remain the only source for mortality data and do provide some basis for evaluation.

Prevalence

The term "prevalence" refers to the number of cases of an illness or condition existing within a population at a given point in time. A distinction is sometimes made between "treated" and "true" prevalence. Treated prevalence is based on data derived from patients actually in treatment. This may be quite different from the actual amount and distribution of illness in a population. One might assume, for example (and as some authorities have suggested), that a person with a severely incapacitating condition like schizophrenia is very likely to come to the attention of a treatment facility at some point. Someone with a milder disorder, such as a neurosis, might or might not come to a facility, depending on factors like how he or she defines the illness, a fear of stigmatization, the ability one has to hide his distress, etc. Thus, treated figures for schizophrenia might approximate the actual amount in the population at large, whereas treated figures for neurosis might underestimate the problem. This same phenomenon may also be present in the case of a physical illness when the individual is either unaware of the condition or fails to seek care because the problem is not felt by the patient to be of sufficient magnitude to warrant it.

The only means to establish the actual amount of illness in a community is by community surveys, for example, interviewing a sample of the total population. The figures generated by this method constitute "true" prevalence. Our data are all "treated" prevalence.

Incidence

The number of new cases of an illness or condition appearing in a population during a specified time period represents incidence of the condition. "Treated" incidence bear the same relationship to each other as these terms do related to prevalence.

Another problem arises in relation to incidence when an individual seeks care from more than one outpatient or hospital facility for the same condition. When this occurs, each initial visit is coded as "first" for that patient in that facility. Consequently, it is impossible to obtain an accurate incidence (or new case rate) because the individual may be counted twice.

While statistics are valuable in determining needs of population groups, many times they fail to present a total picture due to these and other limitations. Consequently, additional material, including the presentation of some individual case histories of older Indians, is presented and may be found in the appendix.

CHAPTER V

HEALTH PROBLEMS FACING URBAN INDIAN ELDERLY

Introduction

A careful search for data, including the National Center for Health Statistics, reveals the not-unexpected finding that data concerning elderly Indians, especially those in an urban setting are nonexistent. However, by using these and some typical biographical abstracts we believe that certain recommendations can be made from what little is presently known.

Demographic Data

The elderly American Indian has lost one or more spouses by death, as well as several close relatives. The elderly Indian may stand out in any Indian community as a rare and "endangered species," since so many of his same-age friends and relatives will already be

dead. The Indian elderly are four times as likely on the reservation and twice as likely in the urban areas as their white counterparts to live within an extended family. Nine percent of the urban and 17 percent of the reservation Indian families are three to four-generation families.

Based on the 1970 Census figures (which by now are badly out-of-date) we found the following distribution of urban and rural Indian elderly.*

As can be seen in Table I, 16 percent of all adult female and 13 percent of all adult male urban Indians are over 60 years of age. Among the urban Indian adults 7 percent of the females and 5 percent of the males are 70 years of age or older.

TABLE I

DISTRIBUTION OF ELDERLY AMONG INDIANS 20 YEARS OF AGE OR OLDER BY RURAL AND URBAN AREAS

	AGE IN YEARS				
	20-59	*60-69*	*70 & older*	*Total Elderly*	*Total all Adults*
Females	Percent	Percent	Percent	Percent	Percent
Urban	84	8	5	13	100
Rural	75	12	9	21	100
Males					
Urban	87	9	7	16	100
Rural	79	13	12	25	100

To put it another way, nearly 15 out of every 100 urban Indian adults are elderly and six out of every 100 urban Indian adults are very old, i.e., 70 years of age or over. (Out of every 100 rural Indian adults 23 are elderly, while ten are at least 70 years of age.)

Comparing the distribution of elderly Indians between those who reside in the city with those who live in rural areas, mostly on the reservation, we found that a surprising proportion of Indian elderly live in the city. Based on a 20 percent sample of the 1970 Census data on American Indians by age and residence, the following distribution of Indians over 62 years of age is given:

	Urban	*Rural*	*Total*
Over 62 years	23,878 (43%)	31,729 (57%)	55,607 (100%)

Thus, among all elderly Indians (55,607), 43 percent reside in urban areas, a truly remarkable fact. Most of the urban Indian elderly are females (58 percent), often living alone, near their children and grandchildren.

* Most of our U.S. Census data is extrapolated from the DHEW Publication OS 75-122, **A study of Selected Socio-Economic Characteristics of Ethnic Minorities Based on the 1970 Census Volume III American Indians**, Washington, D.C., Urban Associates, Inc., 1974.

Unique Social and Health Problems Facing Elderly Indians in the City.

Nearly all elderly urban Indians grew up on their reservations. Most were born after the beginning of the twentieth century, after the Indian people had been conquered and placed on reservations. These elderly Indians were born of a beaten and decimated people. This generation was seen by whites as being the "vanishing Americans," soon to disappear from the face of the Earth as a distinct people.

But this generation of our elders did not vanish—rather they multiplied. They were unskilled by white standards, often unemployed, and almost always poor. They survived the land grabs and the starvation years. They retained at least part of their tribal languages and customs, withstanding earnest efforts by Bureau of Indian Affairs educators to erase them. Despite the adverse conditions of reservation life, the elders capitalized on the opportunity it provided to be together by maintaining strong kinship bonds, regrouping, and slowly regaining control of their destinies.

Our elderly are the transitional people, standing with one foot in the other tribal ways and one foot in the dominant white world. This generation had the highest birth rate of all American people. Many women bore ten or more children, raising some despite the poverty, disease and neglect of the Indian life during 1920-1950.

When World War II came, some Indians moved into the cities as soldiers or defense workers. They were the vanguard of our present urban Indian population. They made a home in the city, marrying there, raising families there, always "visiting back home," keeping the tribal identities and teaching their children to be proud of being Indian. They helped their families on the reservation with money and services whenever they could. They established the first Indian social and cultural centers in the cities, always banding together with other tribal people to keep their Indian spirits alive. Some came out of Haskell to enter the white world as teachers, professionals, and skilled workers and artists. But most worked in factories or for some branch of the armed forces or for the government, building a transitional life between the reservation and the city. Many married outside the Indian world, but taught their children Indian ways. And many died—without proper or adequate medical care.

The next wave of Indian immigration into the cities began with the BIA Relocation Program in the mid-1950's and has steadily continued to this day. Some came as adults for training and for employment, bringing their families with them. Others came to join their children who were on the BIA "relocation pro-

grams." Often they came for a visit, and finally came to stay. They faced the culture shock of adults reared and accustomed to reservation ways. These are tribal people, cut off from their tribal life and support.

What alternative supports are available to them as they grow old in the city? If they grow sick, who will care for them?

The health problems of urban Indian aged vary according to their social backgrounds and resources. We propose to examine four "examples" of urban situations in which elderly Indians might be found, with special reference to their common physical and mental health problems. The four "examples" are 1) the long-time, stable urban dwellers, 2) the late-comers to the city, following their children and grandchildren, 3) the transient elderly who migrate to and from the reservation, and 4) the isolated elderly living in the midst of the inner city. In each of these examples, the health problems and needs of the elderly urban Indian vary.

1. *The Stable Urban Dweller*

A. Persisting traditional views and habits

In a mobile home park on the outskirts of the city live Mr. and Mrs. Lone Pine.* He is 79, she is 73. They are "retired," living on Social Security benefits from their jobs. Mrs. Lone Pine makes beaded moccasins, customized for each dancer, and Mr. Lone Pine builds whistles for all urban Indian children in the various programs located in the community.

Their small mobile home is a frequent meeting place for Indian friends, relatives and children of all ages. They speak their native language (Comanche) only within their own family, since there are so few Comanche speakers in the city. Their health seems good, compared with others their own age, with a few exceptions. Mr. Lone Pine needs dental care which his small pension doesn't cover, so he goes along eating soft food when he would greatly prefer meat and fresh hard vegetables for his diet. Lately, he is anemic, grows tired easily, but does not get health care—"It's too expensive, and I don't like to wait all day and do that red tape." Mrs. Lone Pine's crippling arthritis causes her constant pain, but she keeps active and says, "It's better to keep going than to give up." She has no medical care, but uses "home remedies" such as lemon juice and hot water to ease her crippling pain. They don't use public welfare to supplement the cost of medical care, because they would have to forego their title to Indian lands, as they "have too much" to qualify. They are "too proud and stubborn" to ask for "charity"—so "We'll make out—we're doing okay."

* All names and identities have been changed to protect the urban Indian elderly who shared their lives with us.

B. "The first in his tribe"

John, at 78, lives alone in an apartment downtown selected to retire to while he was still an active teacher in a local college. His fellow faculty members used to be startled now and then to be reminded he was an American Indian, since his position was a result of his expertise and scholarship and was in no way related to more recently developed Indian studies and affirmative action programs. It was not that John denied his identity so much as that in that context it had never come up as relevant.

The first of his family to finish high school and the first of his tribe to go off to college, John found no way to go back home to live after graduation. His land allotment was sold to finance his education and no jobs for an academic person existed. For many years his career developed away from any Indian connections, although he was aware that some of his more creative professional work had its roots in tribal culture and wisdom applied to other contexts and other peoples.

Once established and with some leisure and funds, he sought out others like himself and formed a professional and social alliance with other Indians; each, alert for young with potential, lent their resources and supports to an increasing number of young people who sought out higher education and training beyond high school. Their role is distrusted by the younger folk who sometimes resent the discipline required to work for degrees and licenses; it sometimes bewilders the reservation and tribal leaders who are not sure that John really has a right to lobby, write and speak for Indian causes.

A family of a small local tribe adopted John a number of years ago and provides some sense of family. Students he has trained are all over the country, many now working in tribal businesses and schools or in settings provided by urban Indian organizations. Ironically, John has none of the benefits or privileges many of these take for granted. He has only his earned pension and Social Security to live on. He has no access to medical services and no voting privileges in either his own tribe or the one which adopted him. When Indian militants stir up a backlash he gets caught in it but when they win a concession he usually cannot benefit. But John is not bitter. If pressed, he would admit to loneliness and tiredness—but he sees himself with a foot keeping the doors open until others come along to push them wide.

Comment: These cases illustrate the complexity of the problems faced by isolated urban Indian elderly. The denial of services by welfare departments because of owning restricted land is a cruel situation. The denial of services by BIA and IHS because of prior land sales and/or off-reservation residence is not understood by non-Indians. Retention of Indian

identity is often challenged by those whose ties to a reservation are more recent and more active. Ways to assist Indians in this category would be most desirable.

2. *Elderly in the Extended Family*

A. Latecomer to the city

Mrs. White Horse is here to live with her daughters and their children. She is 79, but looks younger. Her sons are dead, her husband died many years ago, now the rest of her family live in the city. She doesn't complain, but she doesn't like living in an apartment very well; she is used to looking all across the sky on the reservation. She has only a few hundred dollars a year from her "land claim money"—land which is leased out by the BIA to cattle ranchers. It is not enough to live on, but the land value is too high to permit her to receive public welfare even if she wanted to. So she stays with her daughters and nieces, visiting each household where she spends most of the time with the children, and watching TV. She is quiet and sad, when she used to be merry and full of jokes. She isn't as active as she used to be. She stays quiet and alone when the children are away, and doesn't talk much to her daughters. She doesn't seem to be interested in much, and sits rocking alone much of the time. She used to make star quilts, but takes no interest now. She doesn't comb her hair or braid it as much as she used to. Her family seems aware of the change, and tries to talk with her. But she only answers them in a word or so, and turns inside herself again. She's not eating much, and she's up at night a lot. But she doesn't complain.... She doesn't "doctor" and is receiving no professional help.

B. A long established urban extended family member.

Letty, in her 70th year, lives in a major city as she has since high school days. After a year at a BIA Boarding School she left and arranged a mother's helper job to pay for her board and room to be able to attend the city public high school. As she tells it—"I knew I was going to have to make my way in the white world and the BIA school wasn't helping me learn how to do that." Her own family lived on a rural reservation which does not seem as remote now as it did then when travel was difficult, telephones unavailable, and radio and television had not developed.

Letty learned a trade, hairdressing, which she could apply at home while rearing her own children as well as find employment nearly anywhere. Her husband, of a different tribe, had an equally steady skilled labor job. On vacations and visits, contact with folks "back home" continued; nieces and nephews often lived with them for schooling and getting started at jobs. Her own children went on to college. Their spouses and grandchildren often visit Letty. Two of her married children live in nearby towns, one is in another state where her husband has a BIA job.

Letty had a first stroke a couple of years ago and her husband's union health insurance provided first rate care in a University Hospital, so that there are few residual impairments. She is, however, dependent on others to drive her back to the reservation for seasonal visits, feasts, and funerals. When her husband died a year ago she was very lonely until a return to the reservation brought her back in contact with family and schoolmates of her own generation. One of them, who needs to visit a specialty clinic regularly, now lives with her in the city, as well as a nephew who is on a work/study program.

Letty is not sure what the future holds, but she is sure that for her and her family the choice to live in the city was a good one and that the ties back and forth to home and family were not stretched to the breaking point.

Comment: Extended families provide support and care for their elder members. In some cases these efforts are not enough to counteract sadness and melancholy, especially when this is evoked by a dramatic cultural shift that is accompanied by uprooting an older person. However, in many cases the viability of the family system is demonstrated in urban settings and in building bridges between city and reservation.

3. *The Transient*

Bill Joe is an Eskimo from the North Slope of Alaska. He was sent to the city on the BIA Employment Assistance program where he was trained as an automobile mechanic in 1957. He returned to his village, but since there were no cars, there wasn't much work. He drank heavily in the city, and continued to drink at home. His family grew away from him, and he made more and more trips down to the "lower 48". Now he is 68 years old, too crippled with arthritis to work, and he has only the minimum Social Security benefit. He has no real home anymore. He has lots of friends among the Eskimos in the city, and visits with them, moving from one home to another. Now he is spitting up blood a lot and he's talking about going back to Alaska so he can go back to the Public Health Hospital where he was treated for TB several years ago. But somehow, he thought he'd wait until spring, since he is often cold and feverish at night. He has no money for doctors—so he'll just wait until spring.

Comment: The intense isolation of city life is well illustrated. The concomitant medical problem compounding this man's alienation is probably exceedingly common.

4. *The Isolated Elderly*

A. The homeless

Tom Wolf lives most of the time in the downtown

park where he meets all of his other Indian "pals." He sleeps on a cot in a garage down in the city's warehouse district. He'd like to go back to the reservation, but he's never been able to scratch that much money together, so he sits in the park under an old oak tree, drinking wine from a bottle in a paper sack. He gets a "check" from the welfare, but it isn't enough to get him back home to upper New York state. He was a "loner" all his life, was in the service, worked part-time jobs all over the country. He's proud of being Indian, and spent some time in an Indian halfway house away from drinking. But the program funds ran out, and he's back in the park, wrapped in his "tokay blanket." He has many other old Indian men to share his park tree with, and they sit in the California sun and talk of better days, gravely passing the bottle around and around. He is "sick in the stomach—can't keep much down, and has the shakes," but he doesn't go to the doctor. He'd like to go back to the Indian halfway house and "get off the booze," but it isn't there anymore.

Comment: The magnification of alcoholism problems in the city are well known. Of all the problems requiring help this may be the most difficult to solve. It seems clear that prevention early in life is the best solution.

B. The disabled

Mrs. Wild Rose is 87 and bedfast in a nursing home. She was moved from her hogan after her son found her paralyzed one morning. The medicine man and all her relatives stayed with her for many days and they had the Blessing Way ceremony. But she couldn't walk anymore and there are no daughters left alive to care for her. They died in a fiery car crash one moonless night on the mountain road. She was moved into a nursing home. She speaks only Apache, and the people there speak English and Spanish. She is alone and her family and friends see her only once or twice a year, since it is so far from the reservation. She stares at the ceiling and doesn't respond much. Now the BIA has hired a paraprofessional who speaks Apache to visit the nursing home once a week to ask Mrs. Wild Rose what she wants. She never wants much, but does ask to go home to be with her family.

Comment: The failure of conventional agencies and programs to deal with the immediate medical problems posed by the elderly is of course not unique to the Indian people. It is hard to visualize any satisfactory solution to the problem of the very old who cannot be cared for by self or family.

These examples represent some of the very real, common mental and physical health problems facing urban Indian elderly in their daily life in the city. Most of these elderly will live out their days in the city, and meet death there. The awareness of the shortness of life and the universality of death is a key to Native attitudes. Unlike many white people, traditional Natives do not try to conceal death or pretend that it will somehow never come. Instead, they may use death's constant presence as a guide to "how to live."

And what of the end of life: how does an urban Indian find death, and what is his farewell to the world?

As the poet, Ohiyesa, has sung:

Death has no terrors for the Indian:
He meets it with simplicity and perfect calm,
Seeking only an honorable end
As his last gift to
Families and descendants...
If one day he is dying at home
It is customary to carry
His bed out of doors
As the end approaches,
That his spirit may pass under the
Open sky.

In the city, there may be few tribal members to carry out the farewell; most urban Indian elderly want to go back to the reservation to be buried "at home." Relatives and friends frequently accompany their elders home to tribal lands on that last journey.

Discussion

Thus, the urban Indian elderly face many health problems in the city, and some meet death there as well, far from their homes on the land.

We have told the stories of Indian people growing old in the city, and their mental and physical health problems. They suffer from arthritis, tuberculosis, alcoholism, heart attacks and strokes, loneliness, and depression. They do not receive a broad range of medical and dental care; most medical care is of an emergency nature only. They do not depend on modern medicine for their state of health—they rely on natural ways. Their depressed state goes untreated. Many drink to mask their loneliness and fear.

Indian Health Service facilities are located on or near reservations, and most urban Indian elderly are too far away to go there. The few urban Indian health and alcoholism treatment programs are understaffed and underfunded. The medicine men and spiritual healers are seldom found in the city.

The health services in the city are tied up with "red tape," and most urban elderly Indians know nothing about cutting through such red tape. They are often too proud to take "charity," but rely on family and friends for whatever care is available. For most physical complaints, they simply say nothing, preferring to treat themselves or to accept the pain without complaint.

Their lack of funds makes health care the last on a

list of needs. Some have land claims which prevent them from obtaining supplemental health benefits. All of these social factors combine to keep them isolated from sound medical care in the urban situation.

Recommendations

1. The first recommendation is for a thorough needs assessment of urban elderly Indians with a sample size sufficiently large to provide meaningful data.
2. There must be health aides in urban areas whose specific function is to care for the elderly. These aides should be educated as to the special characteristics and needs of elderly Indians. They would serve to personally guide elderly Indians through strange agencies and service centers, but in some instances, also provide direct health services.
3. Programs must be specifically devised for urban elderly Indians utilizing a total health approach.
4. Such programs as Meals-on-Wheels must be expanded with particular attention to diets suitable for the elderly Indian.
5. Programs specifically designed to decrease isolation must be implemented. These would be especially helpful if they brought the young and elderly together for mutual benefit.
6. Homemaker Service Programs must be designed to protect the family structure and permit the elderly to remain in the home.

CHAPTER VI

AN ANALYSIS OF DATA RELATED TO THE PHYSICAL HEALTH OF AGING AMERICAN INDIANS

Two indices used by health professionals in evaluating the health status of a population are "morbidity," or disease conditions exhibited by the population, and "mortality," or causes of death. Certain disease states tend to present themselves more frequently in different age groups. For example, chronic illnesses, such as cataracts and congestive heart failure, are more likely to be found in middle-aged and older populations than are gastroenteritis or acute otitis media. Diseases of a chronic nature most often require care over a relatively long period of time, even until the individual's death.

With these observations in mind it would seem appropriate to begin discussion regarding the physical health of the aging American Indian as reflected by the IHS morbidity and mortality data.

As mentioned in Chapter IV, the statistics represent IHS and contract outpatient visit and hospital discharge diagnoses during the fiscal year 1975. Leading causes of death are also included. The reader would be wise to review the section on use and limitations of the data described in Chapter IV.

It is interesting to note that, for selected disease categories, not all IHS Areas used health services in proportion to the size of their service populations. For example, although the Aberdeen Area is estimated to have 51,410 persons, or only 9.62% of the IHS service population, it accounted for 21.76% of the discharges from IHS and contract hospitals in 1975. In contrast, although Indians residing in the Oklahoma Area comprised 21.69% of the IHS service population, they represented only 10.68% of the hospital discharges and 13.15% of IHS APC visits for selected disease categories, by Area in 1975. Five Areas, Aberdeen, Navajo, Phoenix, Alaska, and Oklahoma, used 74.02% IHS contract hospital discharges for selected disease categories, by Area in 1975. Five Areas: Aberdeen, Navajo, Phoenix, Alaska, and Oklahoma used 74.02% and 75.87% of all outpatient and hospital services, respectively. The rates at which various Indian groups utilize health services have an important impact upon the consideration of programs designed for the elderly. Studies are needed to identify those factors responsible for variations in usage rates. (To some extent the variations cited above are probably due to regional differences in the accuracy of the estimates of the population served).

Pneumonia

Pneumonia is the leading *hospital discharge* diagnosis for persons in three age groups 45 years and over, 65 years and over, and over 74 years. (Table 2). The proportion of hospital discharges for pneumonia increases as one ages: 23.32% in those 45 years and over to 31.84% for those over 74 years. This increase might be anticipated because as one ages, one tends to exhibit limited mobility and become more susceptible to environmental and other influences which contribute to this problem. The proportion of *APC visits* for this condition also increases as one ages (Table 3).

Table 4 contains data for APC visits and hospital discharge rates for pneumonia by age for the IHS service population in 1975. The rates of APC visits for pneumonia is three times greater for Indians 75 years and older than for those 40-44 years.

Indians 65 years and older have a rate of hospitalization for pneumonia two times greater than the total U.S. population: 23.9 vs 11.9/1,000 population.

Diabetes

Diabetes was the second leading cause for *hospital discharges* among the IHS service population of all 3 age categories except for those 75 years and older.

TABLE 1

IHS SERVICE POPULATION AND NUMBER AND PERCENT OF IHS AND CONTRACT HOSPITAL DISCHARGES, AND APC* VISITS FOR SELECTED DISEASES BY IHS AREA, 1975

Area	*Population*		*Hospital Discharges*		*APC Visits*	
	Number	*% of Total*	*Number*	*% of Total*	*Number*	*% of Total*
Aberdeen	79,060	14.08	17,479	21.76	288,873	14.91
Navajo	119,562	21.29	12,967	16.14	448,401	23.14
Phoenix	61,601	10.97	12,278	15.28	246,873	12.74
Alaska	58,624	10.44	9,669	12.03	195,505	10.09
Oklahoma	115,845	20.63	8,578	10.68	254,686	13.14
Billings	31,675	5.64	7,146	8.89	140,610	7.26
Albuquerque	40,064	7.13	4,873	6.06	127,984	6.61
Portland	30,068	5.35	4,259	5.30	131,129	6.77
USET	12,446	2.22	2,137	2.66	67,688	3.49
Tucson	12,639	2.25	956	1.19	35,847	1.85
TOTAL	561,584	100.00	80,360	99.99	1,937,596	100.00

* APC—Ambulatory Patient Care

TABLE 2

IHS AND CONTRACT HOSPITAL DISCHARGES BY LEADING ICDA DIAGNOSIS AND AGE, 1975**

Diagnosis	*Age*					
	45 years and over		*65 years and over*		*75 years and over*	
	Number	*% of total*	*Number*	*% of total*	*Number*	*% of total*
Pneumonia	1,426	22.27 (1)	800	25.72 (1)	440	31.84 (1)
Diabetes	1,287	20.10 (2)	480	15.43 (2)	144	10.42 (4)
Chronic Ischemic Heart Disease	573	8.95 (3)	310	9.97 (3)	156	11.29 (3)
Cerebrovascular Disease	508	7.93 (4)	298	9.58 (4)	156	11.29 (3)
Gallbladder Disease	460	7.18 (5)	134	4.31	NS*	NS*
Congestive Heart Failure	454	7.09	298	9.58 (4)	160	11.58 (2)
Cataracts	402	6.28	269	8.65 (5)	109	7.89 (5)
Bronchitis/Emphysema/ Asthma	374	5.84	147	4.73	75	5.42
Hypertensive Disease	327	5.11	122	3.92	38	2.75
Tuberculosis	304	4.75	NS*	NS*	NS*	NS*
Acute Myocardial Infarction	288	4.50	NS*	NS*	38	2.75
Malignant Neoplasms of the Digestive System	NS*	NS*	132	4.24	43	3.11
Glaucoma	NS*	NS*	NS*	NS*	23	1.66
TOTAL	6,403	100.00	3,110	99.99	1,382	100.00

* NS-Non-significant **ICDA-International Classification of Diseases ( ) Rank Order

TABLE 3

IHS & CONTRACT APC*** VISITS BY LEADING ICDA** DIAGNOSIS AND AGE, 1975

Diagnosis	*Age*					
	45 years and over		*65 years and over*		*75 years and over*	
	Number	*% of total*	*Number*	*% of total*	*Number*	*% of total*
Accidents	14,424	7.34 (4)	3,484	5.02	1,271	5.67
Diabetes	63,417	32.28 (1)	20,383	29.38 (1)	5,069	22.61 (1)
Hypertensive Disease	52,700	26.83 (2)	17,675	25.48 (2)	4,961	22.13 (2)
Arthritis	23,059	11.74 (3)	7,638	11.01 (3)	2,857	12.75 (3)
Ischemic Heart Disease	8,790	4.48 (5)	4,558	6.57 (4)	1,746	7.79 (5)
Congestive Heart Failure	6,803	3.46	4,516	6.51 (5)	2,153	9.61 (4)
Allergies/Asthma/ Hay Fever	6,006	3.06	1,335	1.92	NS*	NS*
Chronic Bronchitis/ Emphysema	5,519	2.81	2,222	3.20	881	3.93
Pneumonia	4,701	2.39	2,058	2.97	1,029	4.59
Acute Otitis Media	3,814	1.94	NS*	NS*	539	2.40
Influenza	3,716	1.89	NS*	NS*	403	1.80
Cataracts	3,504	1.78	2,825	4.07 (5)	1,035	4.62
Hearing Loss/Deafness	NS*	NS*	1,389	2.00	471	2.10
Glaucoma	NS*	NS*	1,284	1.85	NS*	NS*
TOTAL	196,453	100.00	69,367	99.98	22,415	100.00

TABLE 4

RATES PER 1,000 POPULATION OF IHS CONTRACT APC* VISIT AND HOSPITAL DISCHARGES FOR PNEUMONIA BY AGE, 1975

Age	*APC Visits*		*Hospital Discharges*	
	Number	*Rate*	*Number*	*Rate*
40-44 years	674	27.6	175	7.1
45-49 years	677	31.1	155	7.1
50-54 years	665	35.7	149	7.9
55-59 years	654	37.1	162	9.1
60-64 years	647	44.2	160	10.9
65-69 years	501	38.6	159	12.2
70-74 years	528	62.6	201	23.8
75 years & over	1,029	86.3	440	36.9

* Non-significant **ICDA International Classification of Diseases ( ) Rank order

*** APC-Ambulatory Patient Care

This disease, however, ranks first in proportion of *APC visits* for the 3 age groups (Tables 2 & 4). The extraordinarily high prevalence of this condition among certain Indian tribes has been well documented (West, 1974; Rushforth, 1971). Diabetes and some of its complications, including cataracts and vascular problems, are presented in Appendix C. In this chapter it is noted that diabetes is a leading factor in heart disease in older Indians. This chapter also stresses the distressingly high rates of gangrene requiring amputation, more than 90% of which is attributable to diabetes. Diabetes is the main cause of blindness in adult Indians of most tribes.

In Table 5 are shown *APC visit* and *hospital discharge* rates by age for diabetes for the IHS service population in 1975. It will be noted that the rate of visits and discharges for this condition gradually increase until age 65, at which point they decline slightly, only to again increase for those 70-74 years. The rates again drop for persons 75 years and older.

TABLE 5

RATES PER 1,000 POPULATION OF IHS AND CONTRACT APC* VISIT AND HOSPITAL DISCHARGES FOR DIABETES BY AGE, 1975

Age	*APC Visits*		*Hospital Discharges*	
	Number	*Rate*	*Number*	*Rate*
40-44 years	7,349	301.4	159	6.5
45-49 years	9,395	431.0	203	9.3
50-54 years	11,280	604.8	199	10.7
55-59 years	10,954	622.0	190	10.8
60-64 years	11,405	780.0	215	14.7
65-69 years	8,684	668.5	178	13.7
70-74 years	6,630	785.6	158	18.7
75 years & over	5,069	425.1	144	12.1

* APC—Ambulatory patient care

Ischemic Heart Disease

The third leading diagnosis for IHS *hospital discharges* for persons 45 years and older was chronic ischemic heart disease. Ischemic heart disease, including acute myocardial infarction, ranked fifth as a cause for *APC visits* for those 45 years and older (Table 3). It was also a significant cause for those 65 years and older and persons over 74 years.

When "vascular disease" is reviewed as a category, however, a different pattern emerges in which it seems to become more significant. For example, the proportion of *hospital discharges* for selected vascular diseases (ischemic heart disease, hypertensive and cerebrovascular diseases) rose from 29.42% among persons 45 years and older to 39.65% in those 75 years and older. A similar pattern was seen in *APC visits*: 34.77% in the former age group and 39.53% in the older population. Proportionately, then, selected diseases of the circulatory system seem to represent a significant problem in the middle-aged and elderly Indian population.

Although the extent of the problem of hypertensive disease among the Indian population is relatively unknown (Mattingly, 1977), this condition tends to be a precursor of other cardiovascular problems, i.e. ischemic heart disease, congestive heart failure, and cerebrovascular disease.

Hypertensive disease may be associated with several underlying factors, including heredity, diet, obesity, stress, and certain renal abnormalities. Additional study is needed to determine the incidence of hypertensive disease of Indians by age, and to identify specific causes for this condition.

In Appendix C is presented evidence that, in many tribes, the previous immunity of Indians to atherosclerosis is being lost. For example, in Oklahoma, rates of atherosclerosis were particularly low in older Indians, but more recently these difficulties have become almost as common in Indians as in whites. It seems likely that changes in way of life account for this phenomenon. Among the possible etiologic factors are increased dietary fat, increased calories, decreasing exercise, increased smoking, increased prevalence of diabetes, and probably increased mental stress.

Table 6 contains *APC visit* and *hospital discharge* rates for selected cardiovascular diseases by age for the IHS service population in 1975. Table 7 contains rates of visits and discharges for the IHS population for cerebrovascular disease by age.

Arthritis

Arthritis of all forms is a significant health problem for Indian elderly, ranking third in frequency of APC visits for persons 45 years and over, 65 years and older, and over 74 years (Table 3). Rheumatoid arthritis and osteo-arthritis (degenerative arthritis) are the two major types of arthritis, as might be expected. In Table 8 it may be seen that the rate of APC visits for this condition increases up to age 65 years and then tapers slightly for older individuals.

APC visit rates for rheumatoid arthritis seem to be quite high in the Indian population in general, but no comparable data for the U.S. population are available for comparison. The rates of APC visits for osteo-arthritis increase with age, as would be expected.

Arthritis is a significant health problem for elderly Indians as it limits mobility and influences one's ability to make use of needed services, including health care. The presence of this condition may also interfere with an individual's ability to meet basic daily needs.

TABLE 6

RATES PER 1,000 POPULATION OF IHS AND CONTRACT APC* VISIT AND HOSPITAL DISCHARGES FOR SELECTED CARDIOVASCULAR DISEASES** BY AGE, 1975

Age	*APC* Visits*		*Hospital Discharges*	
	Number	*Rate*	*Number*	*Rate*
40-44 years	9,116	373.9	35	1.4
45-49 years	10,855	498.0	29	1.3
50-54 years	12,067	647.0	40	2.1
55-59 years	12,048	684.1	42	2.4
60-64 years	13,708	937.5	42	2.9
65-69 years	11,659	897.5	39	3.0
70-74 years	9,548	1,131.4	37	4.4
75 years & over	10,972	920.2	72	6.0

TABLE 7

RATES PER 1,000 POPULATION OF IHS AND CONTRACT APC* VISIT AND HOSPITAL DISCHARGES FOR CEREBROVASCULAR DISEASE BY AGE, 1975

Age	*APC Visits*		*Hospital Discharges*	
	Number	*Rate*	*Number*	*Rate*
40-44 years	75	3.0	15	.6
45-49 years	95	4.3	34	1.5
50-54 years	143	7.6	38	2.0
55-59 years	245	13.9	49	2.7
60-64 years	359	24.5	89	6.0
65-69 years	312	24.0	65	5.0
70-74 years	324	38.3	77	9.1
75 years & over	465	38.9	156	13.0

TABLE 8

IHS AND CONTRACT APC* VISIT RATES FOR ARTHRITIS BY AGE, 1975

Age	APC* Visits					
	Rheumatoid		Osteoarthritis		Other	
	Number	Rate	Number	Rate	Number	Rate
40-44 years	1,491	61.1	879	36.0	776	31.8
45-49 years	1,626	74.5	1,277	58.5	783	35.9
50-54 years	1,651	88.5	1,579	84.6	768	41.1
55-59 years	1,458	99.7	1,777	100.9	726	41.2
60-64 years	1,380	94.3	1,745	119.3	651	44.5
65-69 years	761	58.5	1,514	116.5	430	33.1
70-74 years	617	73.1	1,158	137.2	301	35.6
75 years & over	758	63.5	1,650	138.3	449	37.7

* APC—Ambulatory Patient Care

** Hypertensive, cerebrovascular & chronic ischemic heart disease, acute myocardial infarction, and congestive heart failure

Gallbladder Disease

Gallbladder disease, prevalent in selected Indian groups, fails to rank among the top 5 hospital discharge diagnoses in the middle-aged and older Indian population. Thus it would appear that this condition occurs primarily in those persons under the age of 45 years, and represents perhaps less of a threat to elderly Indians than one might suppose. However, in many tribes, gallbladder disease seems to be more common in older Indians than in age-matched whites. A major factor in the high rates of gallbladder disease in Indians is probably their obesity.

Cataracts

Cataracts, a problem often associated with diabetes, ranks fifth as a reason for *hospital discharges* for Indians 65 years and 75 years and older. Rates for APC visits and hospital discharge for cataracts increase dramatically after age 45 years. It may be seen in Table 9 that rates are 13 times higher in the age category 75 years and over compared to age 45-59 years. This problem could possibly be reduced with better control of diabetes among Indians, although cataracts generally tend to be more of a problem among older people than the young. The fact that this condition ranks so high emphasizes the importance of this simple yet potentially severely disabling malady.

TABLE 9

RATES PER 1,000 POPULATION OF IHS AND CONTRACT APC* VISIT AND HOSPITAL DISCHARGES FOR CATARACTS BY AGE, 1975

Age	*APC* Visits*		*Hospital Discharges*	
	Number	*Rate*	*Number*	*Rate*
40-44 years	60	2.4	9	.3
45-49 years	147	6.7	17	.7
50-54 years	212	11.3	26	1.3
55-59 years	317	18.0	30	1.7
60-64 years	505	34.5	60	4.1
65-69 years	594	45.7	75	5.7
70-74 years	694	82.2	85	10.0
75 years & over	1,035	86.7	109	9.1

* APC—Ambulatory Patient Care

Further attention should be given to cataracts specifically to determine whether special programs might be designed for them. Among the references cited in the chapter on diabetes is a report of K.M. West to the Indian Health Service (1978). That report describes a high rate of undiscovered cataracts in elderly Oklahoma Indians.

Dental Health

Dental health is one of the areas in which there exists an extreme paucity of data related to elderly Indians. Because of inadequate funding, IHS dental services are geared primarily to children. It is known, however, that for the general U.S. population, and especially the elderly, this is a significant health need.

Poor dental hygiene can be a contributing factor to systemic illness. Infections around the teeth and gums can develop into blood infections. In addition, inadequate dentition limits the foods one can eat and is a strong contributing factor to malnutrition. Inadequate and improper nutrition plays a significant role in lowering an individual's resistance to disease.

The problem lies not only in the lack of preventive services to protect one's own teeth, but also there is practically no provision of partial or complete dentures when needed.

Visual and Hearing Problems

Perhaps with the exception of cataracts, visual and hearing problems of Indian elderly have received little attention in the literature. It is well documented, however, that vision and hearing perception decline with age. Older individuals experience difficulty in color discrimination. This, along with a tendency toward blurred vision, limits one's mobility and increases the chance of accidents. When this is coupled with hearing loss and decreased mobility from arthritis, the problem is compounded. As in other ethnic groups, hearing loss seems to be a rather common problem in older Indians. We are unaware of specific data on the scope and character of this problem. It seems likely that present otology services are sub-optimal in many areas.

In the older people of many tribes visual disability has become distressingly common because of high rates of retinopathy and cataract secondary to diabetes. This is discussed in detail in Appendix C. In some tribes trachoma is still common, and this may cause blindness.

Since the ultimate goal of services for an elderly population is to facilitate maximum individual independence, increased attention to visual and hearing problems of Indian elderly would appear to be in order.

Nutrition

One of the most commonly overlooked aspects of good health is the status of nutrition. The medical profession in particular has not given this important topic the attention it deserves. Although a great deal is written about certain dietary habits and food intake of various Indian tribes and groups, there are actually relatively few data that permit one to draw conclusions

at the present time about the exact status of nutrition of Indians.

The acquisition and sharing of food is an important aspect in the social life of the American Indian. For example, the many feasts and the obligation to provide food for visitors is well known. Because of the prominent place that food-sharing occupies in Indian communities, it is frequently difficult or impossible for an individual to follow a strict diet.

Examples of the extreme importance of diet and its relationship to disease are found in diabetes and hypertension. West (1974) has collected data on a large number of Indians which seem to suggest that perhaps the major factor in the development of diabetes is overweight. What to do specifically about this problem, however, is much less clear. In fact, scientists really know very little about certain aspects of obesity. There appear to be more factors associated with obesity than just simple caloric intake.

Although it is undoubtedly based upon experience, an untested hypothesis seems to be that the present nutritional status of American Indians, and particularly elderly Indians, is very bad. This is paralleled to some degree by a number of suggestions that, indeed, the nutritional status of most Americans is bad.

Because nutrition is so important for good health, and because existing data are so fragmentary, perhaps the most important consideration at the present time is the collection of in-depth data relating to all aspects of nutrition of American Indians, including food habits, caloric intake, nutrition, etc.

Mortality

Accidents

Accidents represented the leading cause of death in 1975 for Indians (Table 10). This category will not be dealt with here because a separate paper on accidents is being prepared by the National American Indian Safety Council.

Diseases of the Circulatory System

Although deaths from heart disease are less common among American Indians than the general U.S. population (Clifford et al, 1963), selected diseases of the circulatory system (acute and chronic ischemic heart disease, cerebrovascular disease, and other heart disease) represented approximately one-half of the Indian deaths for persons 45 years and older, 65 years and older, and 75 years and older in 1975. The

TABLE 10

LEADING CAUSES OF DEATH (ICDA* CATEGORIES) BY AGE, 1975

Cause of Death	*Age*							
	All Ages		*45 years & over*		*65 years & over*		*75 years & over*	
	Number	*% of Total*	*Number*	*% of Total*	*Number*	*% of Total*	*Number*	*% of Total*
Accidents	975	34.59 (1)	242	14.66 (2)	92	10.11 (4)	47	9.12 (5)
Acute myocardial infarction	319	11.32 (2)	288	17.44 (1)	185	20.33 (1)	89	17.28 (2)
Cirrhosis of the liver	244	8.66 (3)	130	7.87	23	2.53	8	1.55
Symptoms & Ill-defined conditions	236	8.37 (4)	139	8.42 (5)	87	9.56 (5)	55	10.68 (4)
Cerebrovascular disease	214	7.59 (5)	199	12.05 (3)	54	5.93	31	6.02
Pneumonia	209	7.41	128	7.75	96	10.55 (3)	75	14.56 (3)
Chronic ischemic heart disease	205	7.27	196	11.87 (4)	159	17.47 (2)	101	19.61 (1)
"Other" heart disease**	166	5.89	122	7.39	76	8.35	46	8.93
Malignancies of the digestive system	130	4.61	117	7.09	77	8.46	36	6.99
Diabetes	120	4.26	90	5.45	61	6.70	27	5.24
TOTAL	2,818	99.97	1,651	99.99	910	99.99	515	99.98

* International Classification of Diseases

** Excluding acute ischemic heart diseases & diseases of the heart muscle

( ) Rank Order

percent remained relatively stable for all 3 age groups: 52.88% for those 45 years and older, 54.80% among Indians 65 years and over, and 50.66% for those over 74 years. Acute myocardial infarction was the leading circulatory disease category in each of the 3 age groups. Only among Indians 75 years and older did pneumonia surpass this as a cause of death.

Sievers' (1967) study of Southwestern American Indians shows diabetes mellitus and hypertension to be the two leading associated diseases seen in persons with myocardial infarction. He concludes that apparently tribes with a higher frequency of diabetes, i.e. Pima and Papago, also show disproportionately more myocardial infarcts than those with a lower diabetic prevalence, i.e. Apache and Navajo.

Cirrhosis of the Liver

Cirrhosis of the liver ranked fifth as a cause of death for all those 45 years and older but was relatively insignificant in the other two age groups (65 and older, and 75 and older). Consequently, it would appear that persons die from this disease relatively early. In fact, according to IHS statistics, 32.8% of all Indian deaths for cirrhosis of the liver occurred in persons less than 40 years in 1975; 74.6% occurred in those under the age of 55 years.

Other Causes of Death

Malignancies of the digestive system ranked fifth among the leading causes of death for Indians 65 years and older in 1975, accounting for 8.90% of the deaths for that age group.

The category, Symptoms and Ill-Defined Conditions, ranked among the top 5 leading causes of death for Indians in the 3 age categories in 1975, (as it did for all ages). The reasons and implications for this phenomenon are unclear.

From Table 11 it may be seen that the rate of death by age for cirrhosis of the liver attains increasing importance until age 55. At this point, diseases of the cardiovascular system begin to assume a greater importance as a cause of death. Pneumonia is most strikingly noticeable as a cause of death for Indians 75 years and older.

In Indians of middle age diabetes mortality is excessive by a factor of approximately 4; in elderly Indians diabetes mortality is about twice as common as in whites. In one of the references cited in the section on diabetes it is indicated that this disease is assigned as the underlying cause of death in only approximately ¼ of Oklahoma Indian diabetics in whom diabetes is mentioned on the death certificate. (See Appendix C).

Table 12 presents the rates of leading causes of death for the IHS service (1975) and U.S. populations (1974) by age. It may be noted that the rates for pneumonia and influenza, accidents, and symptoms and ill-defined conditions among elderly Indians exceeds those for the total U.S. population. The relatively high rates for symptoms and ill-defined conditions among Indians probably reflect the number who die without being under a physician's care and for whom no diagnosis or cause of death can be given. While the death rates among older Indians for ischemic heart disease, cerebrovascular disease, and acute myocardial infarction are significant for them, they are considerably less than for the population as a whole. This is especially apparent for those 75 years and older.

Urban Indian Data

In order to obtain input into this report regarding the health of urban Indians, 27 urban Indian clinics and programs were contacted. Of these, only 10 (37.04%) responded despite follow-up contact. Although these data are too limited to permit evaluation, the results are included.

One question asked the program directors was; "What do you feel are the 5 major physical health problems of urban Indians?" The responses are shown in Table 13.

The five problems listed most often were: dental health, drug and alcohol abuse, diabetes, hypertension, and eye problems. Other problems named included: nutritional problems, heart disease, otitis media, respiratory problems, tuberculosis, infectious diseases, accidents, obesity, early childhood diseases, immunizations, physical exams, housing, jobs, and kidney and bladder problems.

Several of the programs indicated they were providing services aimed specifically at elderly Indians. These included transportation, meals, geriatric clinic, day care, and home health care.

For additional discussion of problems encountered by urban Indian elderly, see Appendix B.

Summary

From the foregoing discussion, several factors deserve mention relative to the physical health of the aging American Indian. It must be remembered that the primary data used in this paper were in the form of IHS service population figures. More specifically, these were IHS and contract outpatient visit and hospital discharge diagnoses for 1975. In addition, mortality data for Indians by age were reviewed.

Diabetes, pneumonia, and cardiovascular diseases appear to be the most prevalent physical disease states for the elderly Indian. Since acute myocardial infarction appears to be the second leading cause of death among Indians 45 years and older in 1975, and since the first hours following the attack are the most

TABLE 11

DEATH RATES PER 1,000 POPULATION FOR SELECTED CAUSES BY AGE, 1975

AGE	CAUSES OF DEATH													
	Acute myocardial infarction		Cirrhosis of the liver		Symptoms & Ill-Defined Conditions		Cerebrovascular Disease		Pneumonia		Chronic ischemic heart disease		Malignancies of the digestive system	
	No.	Rate	No.	Rate	No.	Rate	No.	Rate	No.	Rate	No.	Rate	No.	Rate
0-44 years	12	.4	34	1.3	8	.3	3	.1	7	.2	5	.2	5	.2
5-49 years	12	.5	31	1.4	13	.5	8	.3	9	.4	5	.2	6	.2
0-54 years	23	1.2	37	1.9	13	.6	12	.6	11	.5	5	.2	3	.1
5-59 years	38	2.1	20	1.1	9	.5	9	.5	4	.2	12	.6	11	.5
0-64 years	41	2.8	19	1.2	17	1.1	21	1.4	8	.5	15	1.0	20	1.3
5-69 years	44	3.3	7	.5	15	1.1	35	2.6	9	.6	25	1.9	18	1.3
0-74 years	52	6.1	8	.9	17	2.0	32	3.7	12	1.4	33	3.9	23	2.7
5 years & older	89	7.4	8	.6	55	4.6	91	7.6	75	6.2	101	8.4	36	3.0

TABLE 12

LEADING CAUSES OF DEATH RATES FOR IHS SERVICE (1975) AND U.S. POPULATIONS* (1974) BY AGE

Age	*Causes of Death*										
	Ischemic Heart Disease		*Cerebrovascular Disease*		*Acute Myocardial Infarction*		*Symptoms and Ill-Defined Conditions*		*Accidents*		*Pneumonia Influenza*
	IHS	*US*	*IHS*	*US*	*IHS*	*US*	*IHS*	*US*	*IHS*	*US*	*IHS*
40-44 yrs.	.2	.6	.1	.1	.4	.4	.3	.0	2.4	.3	.2
45-49	.2	1.3	.3	.2	.5	.9	.5	.1	2.2	.4	.4
50-54	.2	2.5	.6	.4	1.2	1.7	.6	.1	2.0	.4	.5
55-59	.6	4.2	.5	.7	2.1	2.7	.5	.1	2.0	.5	.2
60-64	1.0	7.1	1.4	1.3	2.8	4.4	1.1	.2	1.8	.5	.5
65-69	1.9	11.2	2.6	2.6	3.3	6.8	1.1	.3	2.2	.6	.6
70-74	3.9	17.1	3.7	4.9	6.1	9.4	2.0	.4	1.9	.8	1.5
75 & over	8.4	43.7	7.6	16.9	7.4	17.1	4.6	1.0	3.9	2.0	6.7

* Vital Statistics of the U.S. 1974, Vol. II, Morbidity, p. 7-150

TABLE 13

MOST FREQUENTLY MENTIONED PHYSICAL HEALTH PROBLEMS OF URBAN INDIANS

Problem	*Number*	*Percent*
Dental Health	6	13.63
Drugs & Alcohol	6	13.63
Diabetes	6	13.63
Hypertension	4	9.09
Eye Problems	4	9.09
Other*	18	40.91
TOTAL	44	

* Included nutritional problems, "heart disease", Otitis Media, respiratory problems, tuberculosis, infectious diseases, accidents, obesity, early childhood diseases, physical exams, immunizations, kidney and bladder problems, housing & jobs.

crucial for survival, early intervention once the individual becomes ill is imperative.

In addition, early detection and prevention of hypertensive disease seems indicated. This condition can be the precursor for other cardiovascular diseases, including congestive heart failure. Not enough is known about the incidence, prevalence, and cause of hypertensive disease among American Indians.

Data related to dental, visual, and hearing problems of older Indians are disturbingly absent. Also, information which exists relative to Indian nutrition is directed primarily to the young population. Such gaps need to be filled in order to more adequately meet these needs of the Indian elderly.

CHAPTER VII

AN ANALYSIS OF DATA RELATED TO THE MENTAL HEALTH OF AMERICAN INDIAN ELDERLY

Introduction

Information about the quantitative aspects of Indian mental health must necessarily come from that obtained by IHS. These data are gathered in a fashion similar to that for "physical" disorders, and are compiled from clinic visits and hospital discharges. They are subject to the same potential errors as are data about physical health. However, these are the only data available, and as such, may indeed provide guidelines for recommendations concerning programs designed to correct existing mental health problems. The methodical approach used in this chapter is the same as in previous chapters, and is described in the Chapter "Methodology."

The diagnosis of "mental disease" in Indians may have little relation to the actual mental or behavioral phenomena within Indian individuals or Indian communities. The diagnosis of mental disease is often very difficult. A determination of what represents deviant or abnormal behavior depends to a large degree upon the beliefs, traditions, and culture *of the observer* as well as that of the subject. For example, Jewell (1952) reported the case of a Navajo man who was considered to be psychotic until appropriate personality and, especially, ethnocultural investigation finally led to his release from an institution. There are a number of instances throughout the world in which a given group themselves do not regard as deviant, behavior which other groups would regard as serious mental aberration. This has led to the development of a number of "cross-cultural" social and psychological studies. The implications for Indian people are obvious. Essentially all psychological tests are devised for groups other than Indian and may not apply to Indians at all. Indeed certain psychiatric concepts of "Western medicine" may not be appropriate for all Indian people. This does not necessarily mean such concepts are not useful. It merely means that care must be exercised in applying these concepts to Indian people in order not to draw incorrect conclusions.

The absence of mental health data specifically directed at elderly Indians is striking. In a recent annotated bibliography commissioned by the National Institute of Mental Health, (Attneave and Kelso, 1977) there were only ten entries (of 500 total annotated) which dealt specifically with the aged. Two of these (Goldstine and Gutmann, 1972; Krohn and Gutmann, 1971) were studies of aging men from a strong psychoanalytic (Freudian) approach, with limited usefulness for the present discussion. Two others (Richek et al, 1971; Lewis, 1941) dealt with the characteristics of elderly women, whose intact traditional cultures permitted healthy adaptations to the later stages of the life cycle. Three (Attneave, 1972; French and Schwartz, 1973; Boyer et al, 1965) dealt with specific cultural grief reaction rituals and the difficulties of adapting to non-Indian customs. Leighton and Hughes (1955) dealt with the former practice of suicide or ritual death among Eskimo when age or disability drained scarce resources. Hurt and Brown (1965) dealt with contrasting culture and drinking problems in young and old. Only one (Benedict, 1972) attempted to give a profile or general description of the aging Indian population as a whole.

Against this paucity of material, the accumulation of personal experience and records from IHS clinics and hospitals is much more comprehensive and factual. The patient records of general medical facilities (hospitals, clinics, and health stations) record mental health-related diagnoses whenever this seems appropriate to the physicians. Mental Health and Social Service personnel use problem-oriented records that contain a different set of descriptive terms. These two types of data for recent years give complementary views of the picture of mental health problems for about one-half the total American Indian and Alaska Native population of the United States. IHS is not as restricted as is the BIA to serving *only* Indians on reservations (except in Oklahoma and Alaska where reservations do not exist). Nevertheless, funding until very recently has been provided for services to generally the same populations as served by the BIA. The Indian Health Care Improvement Act provides for additional services by IHS to urban Indian populations, but Congress has not appropriated the full level of funds required. The IHS data are valuable in giving estimates of the number of visits for various diagnoses but do not permit firm judgements about *incidence* or *prevalence* within communities. Incidence data for

various abnormalities would be very useful, especially when contrasting the elderly Indian to the non-elderly Indian, as well as to the non-Indian elderly. Only in this way could the most sound evaluations of the mental health of elderly Indians be made. Because of differing patterns of use of facilities, and differing manifestations of mental illness, especially between young and old, one must be careful to avoid judgements based simply on the number of people visiting an IHS facility.

An example of an attempt to establish the extent and type of mental disease is that by Martin and co-workers (1968), who applied the Corness Medical Index and the Langer Scale to Indians in Eastern Oklahoma attending IHS clinics. They found that 25 percent of the Indians studied had evidence of psychiatric problems—a figure not significantly different from that for the general population. The use of such "culture-bound" tests that have not been standardized for Indians must be evaluated with a large degree of skepticism. Such studies as this would be much more meaningful if tests specifically devised for Indian communities were developed.

Shore (1974) has proposed epidemiologic studies for the determination of extent and type of psychiatric illness among Indians. He and his co-workers compared clinic diagnoses in Indians in a Northwest tribe to a sample taken from among the tribe itself. They found that the majority of problems in the clinics were of young adult women related to neuroses such as anxiety and depression. However, among the community they found that alcoholism, although a significant problem, was not really defined as an illness and hence, not referred to clinics. Interestingly, their data showed the same incidence of schizophrenia as for non-Indians and they found no instances of manic-depressive psychosis nor of "classic" drug addiction. Thus, there is a small but tantalizing suggestion that Indians may differ significantly from non-Indians in certain psychiatric manifestations.

IHS lists the following conditions under the heading "Mental Disorders" for ambulatory patient care (APC) visits: "Alcoholism", "Organic Brain Syndrome," "Schizophrenia and other Psychoses," "Neuroses," "Personality Disorders," and "Drug Abuse or Dependence." These data are compiled from computer listing from throughout IHS and list the diagnosis arrived at in outpatient clinics and contract facilities for F.Y. 1975.

Overall Data For Mental Health

Trends from both the Service Unit mental health data and the Mental Health Branch data illustrate a common feature: a majority of service contacts are accounted for by persons aged 20-59 years. Data from IHS Mental Health Branch for 1974 yield similar trends. (Beiser and Attneave, 1974). On a proportional basis, the age group 15 to 39 makes the most service contacts. This age group, which accounts for 34.3% of the total reservation population, accounts for 62.3% of all contacts by mental health workers. Persons aged 60 to 79 make up 7.4% of the total population: they account for 5.6% of the mental health contacts. Persons aged 80 and over constitute 1.1% of the population and about 0.8% of total service contacts. Thus, the Mental Health Branch has more contacts with the elderly than does the general medical services as far as mental health problems are concerned. Closer analysis of the mental health contacts reveals that the majority of services fall under "social services" rather than a strictly medical rubric; that is, most of the contacts with the elderly are accounted for by social workers and social work associates working in the Mental Health Branch, rather than by psychiatrists, psychologists, and psychiatric nurses. The fact that social services are often provided under the rubric of mental health may account for some of the differences between the Mental Health and Ambulatory Care figures. For example, ambulatory patient care (APC) data demonstrate that of all visits for mental disorders, 58.88% can be accounted for by those 20-44 years of age. This age group makes up only 27.3% of the total population. By contrast, those 65 years or older contributed only 4.8% of the total APC visits and make up 5.9% of the total population.

Neurosis

The single leading cause of mental disorders as listed by APC visits in 1975 was some type of neurosis, such as anxiety, depression, or other internal conflict. The largest proportion of all the APC visits for neurosis was in individuals less than 40 years. Of a total of 22,458 visits for neurosis, 11,792 (52%) were in this age group (see Table 1). Persons 40-44 years accounted for 12.2% followed by 9.6% for persons ages 45-49 and 11.0% for those 60 years and older. From these data it appears that certain age groups are indeed at some risk of developing neurotic disorders; this is true for those aged 20-54 years. The occurrence of neuroses in those older than this is about what one would expect based upon the representation in the population.

Alcoholism

The second leading cause for APC visits (for mental illness) in 1975, but first among the reasons for hospital discharge of patients with an emotional problem, was alcoholism. There were 18,320 APC visits and 5,331 hospital discharges with this diagnosis (see Table 2). The largest proportion of outpatient visits

TABLE 1

THE NUMBER AND PERCENT OF VISITS TO AMBULATORY CARE FACILITIES BY SELECTED DIAGNOSIS AND AGE GROUPS

FISCAL YEAR 1975

	Total in IHS Service Population		Mental Disorders			Alcoholism			Organic Brain Syndrome			Schizophrenia and Other Psychoses			Neurosis			Personality Disorders			Drug Abuse			"Other"		
Age	No.	%	No.	%	Ratio	No.	%	Ratio	No.	%	Ratio	No.	%	Ratio	No.	%	Ratio	No.	%	Ratio	No.	%	Ratio	No.	%	Ratio
0-19	301,942	53.8	6,906	11.8	0.2	771	4.2	0.1	83	12.7	0.2	314	6.7	0.1	1,419	6.3	0.1	195	16.0	0.3	388	26.4	0.5	3,736	38.3	0.7
20-39	129,223	23.0	27,897	47.6	2.0	10,157	55.1	2.4	128	19.7	0.9	2,937	51.5	2.2	10,373	46.2	2.0	643	52.7	2.3	676	46.0	2.0	3,523	36.1	1.6
40-44	24,383	4.3	6,628	11.3	2.6	2,511	13.6	3.2	29	4.5	1.0	515	11.1	2.6	2,750	12.1	2.8	126	10.3	2.4	111	7.6	1.8	586	6.0	1.2
45-49	21,799	3.9	5,150	8.8	2.3	1,932	10.6	2.7	38	5.8	1.5	387	8.3	2.1	2,151	9.6	2.5	96	7.9	2.0	85	5.8	1.5	461	4.7	1.2
50-54	18,650	3.3	4,083	7.0	2.1	1,280	6.9	2.1	59	9.1	2.7	397	8.5	2.6	1,850	8.2	2.5	52	4.3	1.3	73	5.0	1.5	372	3.8	1.2
55-59	17,611	3.1	2,819	4.8	1.5	781	4.2	1.4	49	7.5	2.4	244	5.2	1.7	1,330	5.9	1.9	38	3.1	1.0	72	5.0	1.6	305	3.1	1.0
60-64	14,622	2.6	1,962	3.3	1.3	421	2.3	0.9	51	7.8	3.0	155	3.3	1.3	1,020	4.5	1.7	26	2.1	0.8	28	1.9	0.7	261	2.7	1.0
65-69	12,991	2.3	1,173	2.0	0.9	232	1.3	0.6	33	5.1	2.2	97	2.1	0.9	642	2.9	1.3	17	1.4	0.6	9	0.6	0.3	143	1.5	0.7
70-74	8,439	1.5	861	1.5	1.0	142	0.8	0.5	61	9.4	6.3	40	0.9	0.6	441	2.0	1.3	11	0.9	0.6	10	0.7	0.5	156	1.6	1.1
75+	11,924	2.1	781	1.3	0.6	93	0.5	0.2	115	17.7	8.4	62	1.3	0.6	362	1.6	0.8	9	0.7	0.3	9	0.6	0.3	131	1.3	0.6
Unknown	—	—	377	0.6	—	108	0.6	—	5	0.8	—	46	1.0	—	120	0.5	—	6	0.5	—	7	0.5	—	85	0.9	—
TOTAL	561,584	99.9	58,637	100.0		18,428	100.1		651	100.1		4,654	99.9		22,458	99.9		1219	99.9		1468	100.1		9,759	100.1	

* Each percent is derived by dividing the number in each column by the total *of that column, NOT* the total in IHS. (i.e. for mental disorders; 0-19 yr: 6906/58637 = 11.78).

** The ratio is derived by dividing by the number in the percent column for each diagnosis, by the corresponding percent that age group makes up of the total in IHS (i.e. for mental disorders; 0-19 yr: 11.78/53.8 = .2

TABLE 2

VISITS TO IHS FACILITIES IN WHICH "ALCOHOLISM" WAS DIAGNOSED

1975

Age	Outpatient Visits		Hospital Discharge			
	Number	% of Total	Number	% of Total	Total Number in the Population	Percent
45 Years	13,439	73.36	3,680	69.03	455,548	81.1
45-54	3,212	17.53	1,034	19.40	40,449	7.2
55-64	1,202	6.56	268	5.02	32,233	5.7
65+	467	2.55	349	6.55	33,354	5.9
Total[1]	18,320	100.00	5,331	100.00	561,584	99.9

[1]Excludes Unknown

(The discrepancy in numbers between tables 1 and 2 can be accounted for on the basis of overlay between some outpatients and hospitalized patients.)

and hospital discharges with this disorder was seen in persons less than 45 years. This group was responsible for 73% of the clinic visits and 69% of hospital discharges for alcoholism. However, this group constituted 81% of the total population. The group at highest risk as represented by APC contacts relating to alcoholism is the group aged 45-54 years. After age 55 years the proportion of APC visits is less than one would expect based upon the representation of this group in the total population.

These data correspond to those mentioned in an earlier chapter for cirrhosis of the liver. It will be recalled that approximately one-half of all the hospital discharges and APC visits for this condition occurred in the 20-39 year age group. In addition, 48.6% of the hospital discharges and 43.4% of outpatient visits for motor vehicle accidents in 1975 were by persons in that age range. There is a dramatic decrease in the number of both APC and hospital visits for alcoholism above age 55 years; less than 10% of APC visits for alcoholism occurred after this age. There are certain major hypotheses to explain this occurrence. These

include: 1) alcoholic patients may die before reaching age 55, 2) alcoholic patients may indeed survive to this age but stop drinking in later years, 3) since these are cross-sectional rather than longitudinal data, it may be that these do not represent trends. Instead those who are presently aged 55 years may in some way be different from those younger, making them less prone to alcoholism. The way to test this hypothesis is to establish trends over a long period of time by doing longitudinal studies.

Psychoses

The third most frequent reason for APC visits and the second most frequent reason for hospital discharges for mental problems among the IHS service population in 1975 was for psychoses. A total of 971 outpatients and 4,608 hospital discharges for psychosis occurred. Proportionately more of those hospitalized for psychosis were under 40 years or older than 60 years. This was not true for outpatient visits (see Table 3).

occurred in persons under 40 years of age. Similarly, of the 935 IHS and contract hospital discharges for suicide and self-inflicted injury, 834 (89.2%) were in this age group. Another 9% were seen in persons 40-54 years, leaving 1.8% in those 55 years and older.

Several hypotheses are suggested paralleling those for alcoholism above: 1) The adaptive crisis of youth seems to heavily influence the occurrence of suicide and suicide attempt. Perhaps by age 55 years those who survive have resolved these conflicts. 2) Perhaps the Indian culture is more supportive of its elderly than is the white culture. Comparative case analysis of the characteristics of the white-Indian elderly suicides and suitable controls would shed light on this question. 3) Perhaps there is a difference between cohorts identified in cross-sectional studies which needs to be examined longitudinally in order to establish whether there is indeed a decreasing *trend* in suicide attempts with age. On the other hand, people who are now young may have grown up under conditions which make them at risk for suicide whereas those who are of an older generation never developed this tendency.

TABLE 3

VISITS TO IHS FACILITIES IN WHICH "PSYCHOSES" WAS DIAGNOSED

1975

Age	*Outpatient Visits*		*Hospital Discharge*			
	Number	*% of Total*	*Number*	*% of Total*	*Total Number in the Population*	*Percent*
45 Years	735	75.70	3,226	70.00	455,548	81.1
45-54	119	12.26	784	17.01	40,449	7.2
55-64	35	3.60	244	5.30	32,233	5.7
65+	82	8.44	354	7.68	33,354	5.9
Total	971	100.00	4,608	99.99	561,584	99.9

Drug Abuse and Dependence

Drug abuse and dependence was the fourth most frequent reason for APC visits for mental health problems, and ranked sixth among hospital discharges. Again these conditions were seen primarily in the younger age groups. Persons 45 years and older accounted for only 19.5% of the APC visits for this category in 1975, and even a smaller proportion (10.0%) of the hospital discharges.

Suicide

In the majority white population, the group at highest risk of suicide are elderly males; this is not the case in the Indian population. Of the 934 outpatient visits for suicide attempts in 1975, 859 (92.0%)

APC Visits Made By Various Indian Age Groups For Selected Mental Health Problems

One way of analyzing the IHS data relating to APC visits for mental disorders is to examine each diagnosis *within* a given age group and to compare the contribution each diagnosis makes to the total mental health visits *within* that same age group. By inspecting the data in this way, it becomes possible to determine the most frequent causes for visits in each age group among the diagnoses listed in Table 4. If one wishes to know what percent of clinic visits were made for each diagnosis such as neurosis, psychosis, etc., in any given age group, one finds how many total visits were made for the category of "Mental Disorders—Total," then divides this into the number of visits for a specific

diagnosis in the same age group. For example, in the age group of 60-64 years, there were a total of 1,962 clinic visits for mental disorders. Reading down the column one finds the breakdown of 1,962 visits as follows: 421 (21.5%) for alcoholism, 51 (2.6%) for organic brain syndrome, 155 (7.9%) for schizophrenia and other psychoses, 1,020 (52.0%) for neurosis, 26 (1.3%) for personality disorders, 28 (1.4%) for drug abuse, and 261 (13.3%) for "other."

Thus, of all the mental health visits occurring within the ages of 60-64 years, one-half were for neurosis. Also, within this group, one out of five visits was for alcoholism. One can study the outpatient visits in this way for each age group. It is even possible to make certain tentative comparisons between the various age groups. For example, alcoholism accounted for about one out of three (37.9%) visits of those aged 40-44 years, but only about one out of five (19.8%) of the visits made by the age group 65-69 years.

However, there are certain things that this table does *not* show. The most important thing that it does *not* show is what the real impact of each diagnosis has upon the total number of Indians of a certain age group in the community. It is very important to understand that the percentages given in Table 4 do not provide any idea of the occurrence of a given disorder among *all* the Indians of a certain age group. For instance, to use the example cited above, the occurrence of 421 visits for alcoholism in the age group 60-64 years is 21.5% of *all the visits* made by this group, but one must not be misled into believing that this percentage (21.5%) means that 21.5% of Indians aged 60-64 years have problems with alcoholism, nor even that 21.5% of all Indian patients with mental health problems had a problem with alcohol. It might be the case, for example, that an alcoholic makes fewer service contacts than a neurotic person, thus diminishing the apparent size of the alcohol problem and inflating the size of problems with neurosis. An entirely different analysis is needed to determine what percent of *all Indians* 60-64 years have a problem with alcoholism (that is, the *rate* of alcoholism for those aged 60-64 years). We will make some observations about "projected rates" later in this chapter.

There is another way to examine the same set of data. This time a new question may be asked, "What is the contribution (expressed as a percentage) that each age group makes to the total visits for *each disease category*? This is entirely different from the question posed in Table 4. In Table 4 were tabulated the kinds of diagnoses (and their frequency) that occurred within each age group. The second question can be examined by tabulating the number of persons in each age group accounting for each diagnosis. This provides another kind of "profile."

This tabulation is shown in Table 1, which uses the same visits as in Table 4, but this time using a different denominator with which to make calculations. If one again uses the same example, examining alcoholism in those aged 60-64 years, one finds the column for "alcoholism" by scanning across the top. The vertical column under this heading ("Alcoholism") then permits one to calculate how much each age group contributes to *all the visits* for alcoholism. This time for the 421 visits for alcoholism one finds a percent of 2.3 which means that of all the visits for alcoholism in 1975, 2.3% were accounted for by those aged 60-64 years. (In Table 4, 421 is 21.5% of all those visits by those aged 60-64 i.e. 421/1,962; in Table 1, the same number 421, is now 2.3% *but this time of all visits* for alcoholism i.e., 421/18,428).

Taking the entire column labelled "Alcoholism" as an example, Table 1 shows that 4.2% of all alcoholism visits were by those aged 0-19 years; 55.1% by those 20-39; 13.6% by those 40-44; 10.6% by those 45-49; 6.9% by those 50-54; 4.2% by those 55-59; 2.3% by those aged 60-64; 1.3% by those 65-69. 0.8% by those aged 70-74; and 0.5% by those aged 75 or more years. One can of course look at each diagnosis in the same way. By so doing one notes that nearly one-half (46%) of the visits for drug abuse could be accounted for by those aged 20-39 years. Indeed of all *visits* for drug abuse, nearly three-fourths (72.4%) can be accounted for by those under the age of 40 years. The breakdown for certain other diagnoses are of further interest. For example, the only disease category which those 60 years or older contribute to in a significant way is "organic brain syndrome." A total of 40.0% of all visits for this disorder could be accounted for by those 60 years or older. Since this disorder is often associated with degenerative diseases such as arteriosclerosis and stroke this is not surprising. In the diagnoses of neurosis one sees again that over one-half of all visits (52.4%) were made by those under the age of 40 years. It is of interest that the older age groups contribute considerably less to each diagnosis, other than organic brain syndrome, than do younger age groups. One cannot conclude from this that the conditions are necessarily less frequent among the elderly since it has been demonstrated elsewhere (Beiser and Attneave, 1974) that an elderly person is less likely to make return visits to a facility than is a younger adult.

It will be obvious by this time to most readers that these kinds of data can be very incomplete or misleading unless one takes into account the *total* number of persons *in each age group*. For example, to say that 52.4% of all diagnoses of neurosis are accounted for by those under the age of 40 years suggests that neurosis is a big problem for those of this age group. It will by now have occurred to some readers that this proportion (52.4%) of all the diagnoses of neurosis may really be explained by the fact that this age group (39

TABLE 4

VISITS TO IHS AND CONTRACT AMBULATORY PATIENT CARE (APC) FACILITIES BY DIAGNOSIS AND AGE GROUP AND PERCENT THAT EACH DIAGNOSIS CONTRIBUTES TO THE TOTAL MENTAL HEALTH VISITS WITHIN EACH AGE GROUP

	All Ages		*0-19*		*20-39*		*40-44*		*45-49*		*50-54*		*55-59*		*60-64*		*65-69*		*70-74*		*75+*		*Unknown*	
	No.	*Per-cent*	*No.*	*Per-cent*	*No.*	*Per-cent*	*No.*	*Per-cent*	*No.*	*Per-cent*	*No.*	*Per-cent*	*No.*	*Per cent*	*No.*	*Per-cent*	*No.*	*Per-cent*	*No.*	*Per-cent*	*No.*	*Per-cent*	*No.*	*Per-cent*
Alcoholism	18428	31.4	771	11.2	10157	36.4	2511	37.9	1932	37.5	1280	31.3	781	27.7	421	21.5	232	19.8	142	16.5	93	11.9	108	28.6
Organic Brain Syndrome	651	1.1	83	1.2	128	0.5	29	0.4	38	0.7	59	1.4	49	1.7	51	2.6	33	2.8	61	7.1	115	14.7	5	1.3
Schizophrenia and Other Psychoses	4654	7.9	314	4.5	2397	8.6	515	7.8	387	7.5	397	9.7	244	8.7	155	7.9	97	8.3	40	4.6	62	7.9	4	12.2
Neuroses	22458	38.3	1419	20.5	10373	37.2	2750	41.5	2151	41.8	1850	45.3	1330	47.2	1020	52.0	642	54.7	441	51.2	362	46.4	120	31.8
Personality Disorders	1219	2.1	195	2.8	643	2.3	126	1.9	96	1.9	52	1.3	38	1.3	26	1.3	17	1.4	11	1.3	9	1.2	6	1.6
Drug Abuse and Dependency	1468	2.3	388	5.6	676	2.4	111	1.7	85	1.7	73	1.8	72	2.6	28	1.4	9	0.8	10	1.2	9	1.2	7	1.9
"Other"	9759	16.6	3736	54.1	3523	12.6	586	8.8	461	9.0	372	9.1	305	10.8	261	13.3	143	12.2	156	18.1	131	16.8	85	22.5
Total Visits for Mental Health	58637	99.9	6906	99.9	27897	100	6628	100	5150	100.1	4083	99.9	2819	100	1962	100	1173	100	861	100	781	100.1	377	99.9

years or younger) may in fact make up 52% of *all th. Indian people*. (As a matter of fact, those aged 0-39 years make up 76.8% of the total IHS Indian population). Because this kind of comparison is so crucial we have provided a column on the left side showing the total number of Indian people in each age group. This column (entitled "total in IHS") permits one to make some very important comparisons that become even more meaningful. If we go back to our old example of the number of visits for alcoholism but this time inspecting the numbers for those aged 65-69 years, we find that they account for 1.3% of all the visits for alcoholism. At this point the question arises as to whether or not this 1.3% can be accounted for on the *basis of population*. That is, do those aged 65-69 account for an unusually large (or small) proportion of *all Indians* in IHS areas is made up by those aged 65-69 years. Reading the table across for those 65-69 years one finds 12,991 Indians of this age range. This 12,991 makes up 2.3% of all the Indian population. If each age group contributed its *proportion* to each diagnosis, one would expect those aged 65-69 years to contribute 2.3% of all visits for alcoholism. However, as shown above this age group contributes 1.3% to the visits for alcoholism. Therefore, those aged 65-69 years are contributing *less* than expected. (This is an example of "adjusting for Age".)

The actual number (or percent) of visits by each age group can be expressed as the *ratio* to that expected based upon the population distribution. If the percent each age group contributes to each disease is the *same* as expected by the size of the population in each age group, the ratio is 1 ("or a one to one ratio"). If the contribution to a disease by a certain age group is *less* than expected from the population data, the ratio will be less than 1; if the contribution is *more* than expected the ratio will be greater than 1.

If one's attention turns back to neurosis, as noted above, 52.5% of all visits were accounted for by those aged 0-39 years. However, one finds that the group aged 0-39 years makes up 76.8% of the population. Therefore, this group contributes *less* than expected to all diagnoses of Neurosis. However, the age group 0-39 years is broken down into two groups, 0-19 and 20-39 years. Looking at each, one finds that the age group 0-19 years contributes *much less* than expected to neurosis (hence a ratio of 0.1) and the age group 20-39 contributes *much more* than expected on the basis of population (hence, a ratio of 2.0. This ratio indicates that this age group contributes *twice* as much as expected to visits for neurosis.)

Inspection of the ratios for each diagnosis and each age group provides some useful comparisons. For example, the suggestion above that there seems to be a sharp drop off of alcoholism as a problem in those 65 years or older is confirmed in this table. The ratio suddenly becomes *less* than 1 for this age group. This compares to a ratio of 3.2 for those aged 40-44 years.

In nearly every category the ratio of actual to expected visits suddenly jumps to greater than 1 between ages 20-45 years. This may suggest that the age group aged 20-45 years is at higher risk of developing mental disorders or alternatively that persons younger than 20 years may utilize health facilities less

frequently. Another explanation could be that medical personnel may have less of a tendency to make psychiatric diagnoses in the young. Even with organic brain syndrome, there is the appearance of an excess number of visits beginning at age 45 years—rather earlier than one might have expected.

In Table 5 is shown yet another way of analyzing the data for APC visits. In this table we have constructed an analysis of *rates of visits* to APC facilities for a given diagnosis within each age group. This rate is calculated by dividing the number of visits made by those in each age group by the total number of Indians within that age group. This rate is expressed as the number of visits per 1000 population. If each visit represented a single person this would give a reasonably accurate *treated prevalence rate*. Even though the data permit only conclusions about *visits* it may be of some value to examine the data in this way. Such an analysis of service trends may generate certain hypotheses which can be subjected to further testing.

It might be useful to study the previous example of the number of visits for alcoholism in those aged 60-64 years in order to illustrate what one can learn from Table 5. Finding the category, "60-64" and reading across, one finds that there were 14,622 Indians of this age in all the IHS Areas together in 1975. From this total group there were 421 visits for alcoholism, for a rate of 28.8 visits/1000 population. The commonest visits in the 60-64 year group were for neurosis, in which the rate was 69.8/1000, about two and one-half times as common as visits for alcoholism.

By inspecting Table 5, one can take each age group and obtain an idea of the rate of visits based on total population within each age group. For example, checking those aged 45-59 years, we find a total population of 21,799. This age group made 5,150 visits for some mental health problem for a rate of 236.2/1000. Examining all the mental health categories listed for this age group one finds the following rates: alcoholism 88.6/1000, organic brain syndrome 7/1000, schizophrenia and other psychoses 17.8/1000, neurosis 98.7/1000, personality disorder 4.4/1000, drug abuse 3.9/1000, and "other" 21.1/1000. Inspection of Table 5 reveals that among those 40-49 years of age, alcoholism and neurosis account for the highest APC visit rates. Neuroses are prominent causes of APC visits in all age groups except those 0-19 years.

From this analysis one may draw certain tentative conclusions. As one gets older from 19 years, there is a dramatic increase in rates of visits for alcoholism within each group to a high of 103/1000 for those aged 40-44 followed by a slow decline until age 75 years where the rate is 78/1000. On the other hand, "neuroses" begin at a lower visit rate in those aged 0-19 years, increasing for each age range until it reaches a maximum of 112.8/1000 within the 40-44 year age range.

For those aged 0-19 years, over one-half of the APC visits for mental disorder visits are classed as "other" (3736 visits/6906 total mental health visits). This undoubtedly represents a variety of situational problems for which adolescents are referred. For the

TABLE 5

THE RATES OF VISITS* (OR "TREATED PREVALENCE") TO APC FACILITIES BY VARIOUS AGE GROUPS FOR SELECTED MENTAL HEALTH DIAGNOSES

	Alcoholism		*Organic Brain Syndrome*		*Schizophrenia and other Psychoses*		*Neuroses*		*Personality Disorder*		*Drug Abuse*		*"Other"*		*Total Visits Mental Health*		*Grand Total [in IHS]*	
Age Group in Years	*No.*	*Visits/ 1000*	*No.*	*Visits/ 1000*	*No.*	*Visits/ 1000*	*No.*	*Visits/ 1000*	*No.*	*Visits/ 1000*	*No.*	*Visits/ 1000*	*No.*	*Visits/ 1000*	*No.*	*Visits/ 1000*	*No.*	*Per cent*
0-19	771	2.6	83	0.3	314	1.0	1419	4.7	195	0.6	388	1.3	3736	12.4	6906	22.9	301,942	53.8
20-39	10157	7.9	128	1.0	2397	18.5	10373	80.3	643	5.0	676	5.2	3523	27.3	27897	215.9	129,223	23.0
40-44	2511	103.0	29	1.2	515	21.1	2750	112.8	126	5.2	111	4.6	586	20.0	6628	271.8	24,383	4.3
45-49	1932	88.6	38	1.7	387	17.8	2151	98.7	96	4.4	85	3.9	461	21.1	5150	236.2	21,799	3.9
50-54	1280	68.6	59	3.2	397	21.3	1850	99.2	52	2.8	73	3.9	372	19.9	4083	218.9	18,650	3.3
55-59	781	44.3	49	2.8	244	13.9	1330	75.5	38	2.2	72	4.1	305	17.3	2819	165.7	17,611	3.1
60-64	421	28.8	51	3.5	155	10.6	1020	69.8	26	1.8	28	1.9	261	17.8	1962	131.4	14,622	2.6
65-69	232	17.9	33	2.5	97	7.5	642	49.4	17	1.3	9	0.7	143	11.0	1173	90.3	12,991	2.3
70-74	142	16.8	61	7.2	40	4.7	441	52.2	11	1.3	10	1.2	156	18.5	861	102.0	8,439	1.5
75+	93	7.8	115	9.6	62	5.2	362	30.4	9	0.8	9	0.8	131	11.0	781	65.5	11,924	2.1
Unknown**	108	—	5	—	46	—	120	—	6	—	7	—	85	—	377	—	—	
TOTAL	18428		651		4654		22458		1219		1468		9759		58637	1520.6	561,584	99.9

* The rate of visits/1000 is calculated by dividing the No. of visits for a given diagnosis in each age group by the *total* IHS population that age (i.e. for 0-19; alcoholism: 771/301,942 x 1000 = 2.6)

** In this instance there is no denominator for those in the IHS population who are of unknown age—the rates would mean little anyway.

category 40-44 years only 7.3% of their total mental health visits (486/6628) are classified as "other." This increase in diagnostic specificity may suggest that medical personnel are more comfortable in dealing with adults. An alternate hypothesis is that pathological characteristics have not yet coalesced into a recognizable entity for those aged 0-19 years. In the age group 70-74, the diagnosis of "other" accounts for 156/861 visits for mental health (18.1%). In the age group 75 years and older other diagnoses have been used in 131/781 visits for a percent 16.8%. Thus the data suggest that in the very elderly there is also a tendency away from diagnostic specificity. This may be explained by the same hypotheses as for the young. Since the category "other" refers to all diagnoses not specifically carried on the printout, it in fact may be incorrect to draw conclusions on age variations based upon its use in the present discussion.

Based upon the number of APC visits, neuroses combined with alcoholism represent the major demands upon the system for all groups. The only logical conclusion that can be drawn is that major efforts should be directed towards these maladies. This includes training more Indians in the mental health professions. What are also needed are programs designed to provide relief from a hostile world, with personnel to implement them. These efforts should parallel those aimed at strengthening those tribal and individual forces that help preserve a sense of well-being. These conclusions coincide with recommendations made by the President's Commission on Mental Health (1978).

There is another source of data that may be useful in obtaining an idea of the impact of mental health problems on the elderly Indian. Beiser and Attneave (1974) collected extensive information about Indian mental health by utilizing computer listings as a means of evaluating staffing of the Social Service-Mental Health Branches of the IHS. These data are the first that contain information about the number of *patients* rather than the number of visits. In addition to this characteristic these data are collected from a separate reporting system unique to the Mental Health-Social Service Branches and therefore differ from the APC data described above. Patients counted in this system may be referred by the professional workers in the APC system or may be self-referred or referred from a number of other sources.

Beiser and Attneave found that during calendar year 1974, there were 29,996 patients seen for social or mental problems. This number was made up of 12,777 males and 17,219 females. There were 15,531 visits made *for the first time* of which 6,788 were males and 8,763 females. The disproportion for females is obvious. The authors describe a treated prevalence rate of 5.1% for males and 6.6% for females. The treated incidence rate for males was 2.7% and 3.3% for females.

Disregarding for the moment those visits for social services and examining only the visits for mental health one finds that during this year there were a total of 14,414 patients seen of which 7,355 were seen for the first time. This gives a treated prevalence rate of 2.8% and a treated incidence rate of 1.4% based upon a total Indian population of 515,377.

The mental health data collected by Beiser and Attneave are further broken down by age as shown in Table 6. This permits the best estimate of the impact of mental disease within each age group with that upon another group. Note that the numbers for total popultion in each group are not exact. The greatest "treated incidence" rate (2.21% occurs in the age groups 21-30 years, followed by those aged 31-40 years (2.11%), following which it drops progressively to 1.26% for those aged 61-70 years. Does this mean that the mental health of Indians improves in older age? Not necessarily. A number of other factors may be important. For example, older persons may simply not be visiting the health facilities, even though they may have a very significant problem. Another interesting aspect is that in the rapidly changing world, there may be significant age differences that will only be discovered as time goes by. For example, it would be very interesting to follow the 21-30, and 31-40 year age groups through each succeeding decade of their life to determine if there will be a change in the

TABLE 6

THE NUMBER OF NEW CASES (INPATIENT AND OUTPATIENT) SEEN BY MENTAL HEALTH SERVICES OF ISH

1974

Ages in Years	*Total Population**	*No. of New Cases*	*Rate (New Cases) Expressed Incidence/1000 population*
0-20	301,942	2,658	08.8
21-30	72,027	1,589	22.1
31-40	57,196	1.207	21.1
41-50	46,182	809	17.5
51-60	36,261	501	13.8
61-70	27,613	349	12.6
71-80	13,983	173	12.4

(Extracted from Beiser & Attneave)

* Figures for total population are not exact and are based upon a breakdown by age of 0-19, 20-29 yrs. etc., but for this analysis the error will be quite small.

treated incidence rate for each. It may indeed continue high, possible indicating that something has marked each group in such a way that a disproportionate number of visits will continue into old age.

The expected proportion of visits to the Mental Health and Social Service Branches for each age group and the observed proportions of visits by each are shown in Figure 1. There is a sudden preponderance of actual visits over expected visits appearing in the age group 21-30 years, which persists even until age 90 years.

Examining the data in Table 6 which deals with new cases and those in Figure 1 comparing the number of visits by group with what would be expected on a proportional basis, one can safely conclude that patterns of retention within the service vary by age (Beiser and Attneave, 1974). Generally speaking, young and middle-aged adults are more apt to appear for service for the first time, but in addition, once so identified, these adults are more likely to be retained by the service than are the elderly.

One explanation for this phenomenon is that the middle-aged group may be more apt to see mental health services as relevant to their problems. Another might be that precipitating factors are of greater magnitude in this age group, thus increasing the actual number of mental disorders and hence leading to greater utilization. Another hypothesis of course is that the elderly are under serviced even though their needs may be as great as other age groups. Finally, one might suspect that mental health personnel find it more difficult to deal with the elderly than with younger age groups, and therefore do not accumulate as large case loads of the elderly. Support for the last hypothesis comes from two observations: One, even when an elderly person comes for service the first time, he or she is less likely to be seen for follow-up visits than a younger counterpart. Secondly, and perhaps at another level of influence, diagnoses of mental health problems as "other" are made more frequently in describing elderly patients than in young or middle-aged adults.

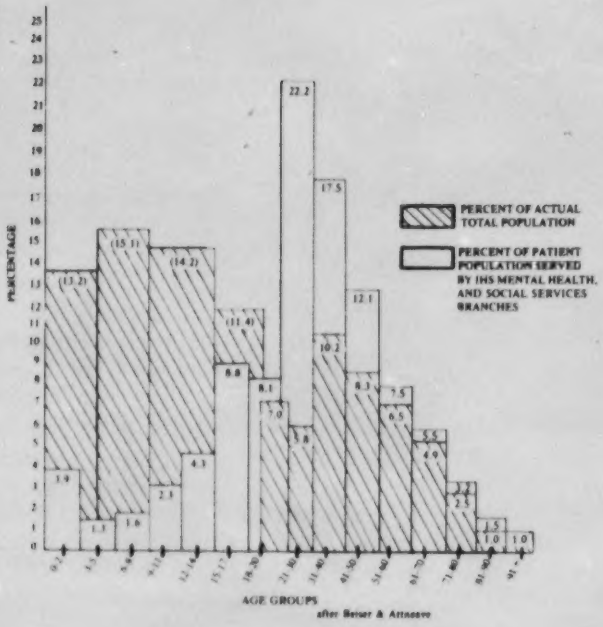
PERCENTAGE
AGE GROUPS
PERCENT OF ACTUAL TOTAL POPULATION
PERCENT OF PATIENT POPULATION SERVED BY IHS MENTAL HEALTH, AND SOCIAL SERVICES BRANCHES
after Beiser & Attneave

Figure 1. Percentage of patient contacts in Mental Health and Social Services of IHS by age groups.

Further Observations Relating To Mental Health of Elderly Indians. Data Collected from Certain Area Offices of IHS

In order to gain greater insight into mental health problems of American Indians, each Area office was requested to provide an assessment of mental health problems within each Area. However, data permitting analysis were obtained only for the Portland and Albuquerque Areas. Because these reports increase one's understanding of mental health problems and provide certain useful information, they are included in this report.

Portland Area of IHS

Data relating to mental (and social) services for Portland Area of IHS in 1977 illustrate the kinds of problems seen at the Area level. They also permit an idea of the relative frequency with which Indians of certain age groups are referred to a Social Service-Mental Health Branch in the Area. The number of visits and the reason for the visits are shown in Table 7 which lists the total number of visits and the number of visits by Indians of age groups 45-54, 55-64 and 65 years or older. A total of 344 visits were made during this time. Over one-half of the visits were accounted for by those aged 45-64 years. The fewest visits, 20.0%, were by those over the age of 65 years. There is considerable variation in the contribution made by each age group for each problem. For example, of 39 visits for anxiety, 18 (46.2%) were accounted for by the age group 45-54 years whereas only 6 (15.4%) were accounted for by those over 65 years of age. Of all the causes of visits in this age group, anxiety ranked fourth in order after chronic physical illness (No. 1), nursing home (No. 2), and adult-child relationships (No. 3). For those between ages 45-54 years the leading reasons for visits were: 1) Adult-child relationships, 2) Alcohol misuse, 3) Depression, 4) Anxiety, and 5) Alcohol misuse in the family. There was a shift from the ranking for those in the next older group,

TABLE 7

PORTLAND AREA

FY-77

	Total By Ages			
	Total	45-54	55-64	65 & older
Adult-Child Relationships	*(1) 58	(1) 35	(1) 16	(3) 7
Alcohol Misuse	(2) 46	(2) 31	(4) 11	4
Alcohol Misuse-Family	(5) 25	(5) 15	5	5
Anxiety	(4) 39	(4) 18	(2) 15	6
Depressed	(3) 42	(3) 25	(3) 14	3
Financial Assistance	14	6	4	4
Financial Needs	9	5	1	3
Isolation, Phys/Soc.	5	-	2	3
Mental Illness-Family	17	10	3	4
Mental Retardation	6	1	1	4
Nursing Home	11	2	1	(2) 8
Peer-Sibling Conflict	17	(6) 14	1	2
Physical Disability	12	5	4	3
Physical Illness-Acute	1	-	1	-
Physical Illness-Chronic	18	4	5	(1) 9
Other	(6) 24	(7) 12	(5) 8	4
TOTAL	344	183	92	69

* (1) = Rank order

(Data kindly supplied by Billie Von Fumetti, Chief, Mental Health for the Portland Area.)

55-64 years, where the ranking was as follows: 1) Adult-child relationships, 2) Anxiety, 3) Depression, 4) Alcohol misuse, and 5) "Other."

The Albuquerque Area of IHS (FY 1977)

The total Indian population in the Albuquerque Area was 36,979. Of this, 3,610 (9.8%) were aged 45-59, and 3,063 (8.3%) were 60 years or older. Thus, of the entire population in the Albuquerque Area, 18.1% were aged 45 years or more.

The ten leading psychosocial problems in the Albuquerque Area for FY 1977 listed in order of frequency for those aged 45-54 years and those 65 years or older are shown in Table 8. These data were compiled from a checklist of problems for which referrals were made to the Social Service-Mental Health Branch, similar to that for Portland Area shown in Table 7. For those in the 45-64 year age group, alcoholism is the most frequent (20%) followed in order by depression (17%), financial needs (14%), chronic physical needs (12%), anxiety (9%), acute physical illness (9%), physical disability (7%), health homemaker needs (5%), confusion-disorientation (4%), and nursing home (3%).

This compares to the ranking for those 65 years or older as follows: physical illness, chronic (19%), nursing home (16%), financial needs and assistance (13%), health homemaker needs (11%), depression (9%), third party claims (9%), physical disability (8%), confusion-disorientation (6%), alcohol misuse (5%), and acute physical illness (4%). It is of interest that anxiety is not included in the top ten psychosocial problems encountered by those 65 years or older. Alcohol abuse ranks ninth and accounts for only 5% of responses on the checklist for the older group.

A comparison of "extrapolated" treated prevalence for selected diseases between the two age groups is shown in Table 9. The "extrapolated" treated prevalence is calculated by dividing the number of persons with a problem by the total number of persons in the community, and in this case, expressed as the number of cases per 1000 population. As has been pointed out previously, those coming to IHS facilities with a certain problem may represent only a small fraction of those in the community who have the same problem.

These data are extremely interesting. The "extrapolated" treated prevalence for "psychosocial" problems is extremely high for both groups: 130.5/1000 for those 45-54 years compared to 97.3/1000 for those 65 years and older. Even so the figure of 97.3/1000 is far from negligible. The very old use these services somewhat less often than do middle and younger-aged persons. Whether because they have fewer problems, or whether they are staying away for some other reason is not clear. Answers to these questions would be very useful.

There is a sharp drop in the "extrapolated" prevalence for alcoholism, probably indeed reflecting less alcoholism in those over the age of 65 years. The possible explanations for this have been described earlier in this report. The reason for the decreased "extrapolated" treated prevalence rates for both anxiety and depression in the group 65 years and older is less clear. One possibility is that indeed there is less depression and anxiety among those who survive to age 65 or that the manifestations of anxiety and depression are less clear in the elderly, leading health workers to utilize the label "other" or those of various somatic complaints. The apparent lessening financial burden bears further study also. It may represent old age assistance but this needs verification. The sudden rise in need for nursing homes is as expected.

The Albuquerque Area IHS has established a committee for aging activities with a specific set of objectives for each fiscal year. The chief IHS social worker serves as coordinator for aging activities in each service unit. There has been close collaboration by both IHS and Indian communities with the Gerontology Unit of the University of New Mexico, and a number of activities are ongoing throughout the area. This pattern appears to be utilized in several other Areas of IHS, for example, the Oklahoma Area.

Discussion

Any conclusions based upon existing data must be very carefully and tentatively interpreted. Although

TABLE 8

TEN LEADING PSYCHO-SOCIAL PROBLEMS IN RANK ORDER FOR AGING AND AGED, ALBUQUERQUE IHS AREA, F.Y. 1977

Ages 45-64 Years			*Ages 65 and Over*		
Problem	*Persons*	*%*	*Problem*	*Persons*	*%*
Alcohol Misuse	94	20	Physical Illness, Chronic	56	19
Depressed	79	17	Nursing Home	49	16
Financial Needs & Assistance	66	14	Financial Needs & Assistance	40	13
Physical Illness, Chronic	57	12	Health Homemaker Needs	33	11
Anxiety	42	9	Depressed	26	9
Physical Illness, Acute	41	9	Third Party Claims	26	9
Physical Disability	34	7	Physical Disability	23	8
Health-Homemaker Needs	23	5	Confused-Disoriented	18	6
Confused-Disoriented	19	4	Alcohol Misuse	15	5
Nursing Home	16	3	Physical Illness, Acute	12	4
TOTAL	471	100	TOTAL	298	100

TABLE 9

ALBUQUERQUE AREA IHS.
PERSONS REPORTING TO IHS FACILITIES WITH PSYCHO-SOCIAL PROBLEMS IN F.Y. 1977

	Age: 45-64 Years			*Age: 65 Years and Older*		
	No. with Given Problem	*No. in Albuquerque Area*	*"Extrapolated" Prevalence Rate Per 1000/Population*	*No. with Given Rate Per*	*No. in Albuquerque Area*	*"Extrapolated" Prevalence Rate Per 1000/Population*
Alcohol Abuse	94	3,610	26.0	15	3,063	4.9
Depressed	79	3,610	21.9	26	3,063	8.5
Anxiety	42	3,610	11.6	—	—	—
Confused/Disoriented	19	3,610	4.3	18	3,063	5.9
Financial Needs	66	3,610	18.3	40	3,063	13.1
Nursing Home	16	3,610	4.4	49	3,063	16.0
Total Psycho/Social	471	3,610	130.5	298	3,063	97.3

(Kindly provided by Mrs. Vesta L. Starkey, A.C.S.W. Chief, Social Service Branch)

there are indeed a lot of data, the way in which they are collected presently is open to considerable error. Only very crude estimates are permissible. With this in mind it appears that certain inferences can be drawn. It seems justifiable to conclude that there is a problem with "mental health" of the elderly Indian. The extent and impact of this problem, and the factors relating to it, cannot yet be precisely defined. What is most noticeable from the data is that the magnitude of the problem in the elderly is only a fraction of the problem among the young adult and middle aged, at least as measured by the number of visits recorded in the present systems. The pattern of visits compared to the number of persons presenting for treatment in different age groups, however, raises fundamental questions demanding further investigation. For example, we need to know whether a lower utilization of facilities by the aged means that they harbor fewer mental health problems than do younger persons or whether there are selective barriers to treatment that exist for the elderly.

An example of a problem which appears to diminish with age is alcoholism. The rates of visits for severe conditions such as schizophrenia, as estimated from the scanty data, do not appear to differ greatly from the rest of the population in the United States. However, there is a suggestion that manic-depressive psychosis may be less common among Indians than among non-Indians.

Although a great deal is known about the mental health needs of the elderly American Indian, a great amount of additional information is needed. Little systematic data regarding Indian mental health has been collected. In the past few years there has been a dramatic turnaround in attention to mental health problems as witnessed by the rapid growth of the mental health program of the IHS.

Appropriate research would include the development of culture-specific testing instruments for Indian communities; the collection of data that would permit comparisons between Indian elderly and non-Indian elderly; research into factors which place people in position of high risk for the development of mental disorders; and preventative programs. Because the problems are complex and because they arise from a variety of factors, a comprehensive multidisciplined approach is needed. The recommendations by the Subpanel on Mental Health of American Indians and Alaska Natives, President's Commission on Mental Health (1978) should be supported.

In this analysis we have identified areas in which further research is likely to yield great benefit. These include further study of patterns of alcoholism as they relate to age; a comparison of Indian and non-Indian suicide patterns as they relate to age; patterns of utilization of mental health resources as related to age; and perceptions of the elderly by health personnel.

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APPENDIX A

CASE STUDIES OF INDIAN ELDERLY

Approximately 400 Indian patients in nursing homes throughout the state of Arizona are supported in total or in part by Indian Health Service and/or Bureau of Indian Affairs. There is no "Medicaid" program supplying nursing home services to indigent persons in Arizona, and the county welfare programs regard tribal groups to be ineligible for their services. Therefore, federal agencies administer these programs for Indian patients either directly or through contacts. Nearly one half the total number of Indian patients placed in long-term care facilities are located in the Phoenix metropolitan area, where the vast majority of beds and special services are located. The medical staff at Phoenix Indian Medical Center provides services directly to Indian patients in Phoenix long-term care facilities.

Although no mortality or morbidity data are currently being assembled on nursing home patients as a separate group, it is highly probable that the data would be comparable to the data on the hospitalized population in the same age groupings.

Several case histories are included in this paper to graphically illustrate problems of the long-term care population. It should be pointed out that these case studies do not include younger age groups who are also occupying long-term care facility beds in sizable numbers, and require a separate analysis, nor do they include elderly who are in long-term care facilities for brief periods of convalescence following an accident or other self-limiting conditions.

The major problem associated with elderly patients in particular is the existence of multiple diagnoses along with multiple medications. Our case histories bear out this phenomenon. Attendant with the aging process is the ever-declining ability to metabolize and eliminate these medications. The result is an ever-increasing hazard of drug intolerance and side effects. Special attention and expertise must be exercised in medical management of the elderly.

It will be noted in the case histories that most elderly patients have special diets prescribed to meet individual requirements. This is a special burden upon the Indian elderly who also must forego traditional diets upon arrival at long-term facilities. Few long-term care facilities are willing to make substantial changes in menu planning and food preparation to accommodate the tastes of the various tribal groups.

Perhaps the most serious problem faced by the Indian elderly placed in long-term facilities is their nearly universal feeling of rejection and isolation from all that is familiar to them. Coupled with the feeling of rejection by the family is the tendency of the long-term facilities to operate primarily in the interest of furtherance of their own institution's goals rather than patient-oriented goals. The nearly invariable result is depression and mental and physical deterioration which may require months to overcome. Many elderly patients would prefer bare survival conditions at home, including inadequate food, shelter, and personal care, and even premature death, to incarceration in long-term facilities.

As life expectancy increases in the Indian population and the numbers of elderly in varying states of declining health continues to grow, it is clear that ways must be found to accommodate increasing numbers in their own homes, or at least in their own communities. This is *the challenge* of the next decade. These people must find ways to spend their latter years meaningfully. To accomplish this, they themselves must develop skills necessary to make these added years meaningful, perhaps with assistance and encouragement from tribal and other agencies.

Higher priority must be given to the provision of medical, social, and environmental necessities of life in their homes and communities. The inter-agency organizational framework to accomplish this already exists. What is needed is a steady transfusion of financial support to agencies supplying visiting nurses, home health workers, day chore workers, transportation, housing and repair, and communication services.

Case Study #1

Name	*Date of Birth*	*Tribe*	*Date Admitted to Nursing Home*
Q.D.	1923	Hopi-Tewa	12-10-73

Diagnoses:
1) Pulmonary tuberculosis, inactive
2) Bilateral upper lobectomies
3) Chronic obstructive pulmonary disease, both lower lobes.
4) Cor Pulmonale
5) Old myocardial infarction with mild congestive heart failure

This 55-year-old traditional Hopi bead worker suffered extensive damage to his lungs following a long siege of pulmonary tuberculosis twenty years ago. He has approximately one-third normal lung capacity and a weakened heart making life up on the Hopi Mesas impossible for him. He continues to do bead work at the nursing home.

A Hopi medicine man visits him regularly and prescribes herbal medicines for him in cooperation

with the attending physician, who signs the orders for the medicine man.

Case Study #2

Name	*Date of Birth*	*Tribe*	*Date Admitted to Nursing Home*
R.N.	4-22-14	Pima	5-16-75

Diagnoses:
1) Diabetes mellitus
2) Diabetic nephropathy and retinopathy
3) Bilateral cataract extractions, 1976
4) Chronic alcohol abuse
5) Pulmonary tuberculosis, treated, inactive
6) Anemia of chronic diseases
7) Osteoarthritis

This 64-year-old Pima woman is well oriented and surprisingly independent in spite of her numerous potentially debilitating conditions. Her primary goal is to enjoy the free-living life style she had in earlier years. On three occasions she has signed herself out of the facility against advice, only to return to Phoenix Medical Center with life threatening infections and/or ketoacidosis. Her latest hospitalization was in February, 1978, after an absence of only 5 days from the nursing home.

Case Study #3

Name	*Date of Birth*	*Tribe*	*Date Admitted to Nursing Home*
J.G.	3-19-12	Pima	7-19-73

Diagnoses:
1) CVA, left hemiparesis
2) Diabetes mellitus
3) Congestive heart failure with bilateral pleural effusions
4) Pulmonary tuberculosis, treated, inactive

This 65-year-old Pima man had great difficulty adjusting to the nursing home. Attempts to involve him in occupational, recreational and physical therapy activities resulted in increasing agitation and hostility. He was transferred to another nursing home which has a very tranquil atmosphere with almost immediate improvement. Tranquilizing medications have been considerably reduced and the patient has only infrequent flares of temper. He is confined to a wheel chair but is well oriented and knows very definitely what he does and does not want to do. He adamantly refuses to participate in typical nursing home activity programs.

Case Study #4

Name	*Date of Birth*	*Tribe*	*Date Admitted to Nursing Home*
B.S.	5-28-14	Pima	3-1-76

Diagnoses:
1) Skull fracture, cerebral contusions, receptive and expressive aphasia, and hemiparesis
2) Syndrome of inappropriate autiduretic hormones
3) Chronic alcohol abuse
4) Seizure disorder

This 63-year-old Pima male was discovered comatose in Socatone, Arizona, in February, 1976. Initial treatment was given at Barrows Neurological Institute and Phoenix Indian Medical Center. Attempts at long-term physical and mental rehabilitation in the nursing home were unsuccessful. Speech, comprehension, and physical coordination initially returned to a moderate extent, and syndrome of inappropriate antiduretic hormones disappeared. In October, 1976, he fell and sustained a hip fracture requiring surgical repair. The following year he was hospitalized twice for seizures and declining mental functioning, including outbursts of violent behavior. In October, 1977, he was admitted again for complete neurological assessment. No new pathologic findings were found on Xrays, EEG and CT scan other than progressive cerebral degeneration. He was subsequently transferred to Arizona State Mental Hospital to allow him maximum freedom of movement without exposing himself or others to possible injury from his unpredictable behavior.

Case Study #5

Name	*Date of Birth*	*Tribe*	*Date Admitted to Nursing Home*
A.M.	6-12-1897	Navajo	6/75

Diagnoses:
1) Chronic organic brain syndrome with marked memory loss and depression
2) Hypothyroidism
3) Bilateral hearing loss
4) Bilateral macular degeneration
5) Bilateral hip fractures (repaired surgically)
6) Osteoarthritis

This charming, intelligent 80-year-old Navajo woman is a retired school dormitory supervisor. Following her last hip fracture she was transferred to a Phoenix nursing home for convalescence and long-term care. With glasses, hearing aid, and dentures she is quite independent, and ambulatory with a cane. Her initial profound depression has improved considerably, although she still longs to be back home with her dormitory children. She is an excellent conversationalist and plays the piano to entertain the other residents. It is perhaps fortunate that she cannot recall that she has been away from home nearly two years, for she would undoubtedly become deeply depressed all over again.

Case Study #6

Name	*Date of Birth*	*Tribe*	*Date Admitted to Nursing Home*
M.S.	6-19-16	Pima	1974

Diagnoses:
1) Severe deforming osteoarthritis, both ankles
2) Exogenious obesity
3) Mitral stenosis with mild congestive heart failure
4) Decubitus ulcers

This 61-year-old Pima man was admitted bedfast to a nursing home four years ago. In his younger years he had been chronically ill, unmarried, and unemployed. He has undergone major surgery (triple arthrodesis) to straighten out his ankles and enable him to stand. He has lost more than thirty pounds, and has regained sufficient strength in his extremities to permit ambulation with a walker. A long series of porcine grafts have finally healed his decubitus ulcers, and he now plans to return to his home in the near future. He feels as if his life is just beginning at age 61.

Case Study #7

Name	*Date of Birth*	*Tribe*	*Date Admitted to Nursing Home*
R.H.	1908	Pima	1968

Diagnoses:
1) Glaucoma, cataracts, blind
2) Emphysema

This 70-year-old Pima man has been blind for twenty years. Unmarried and disabled for many years due to visual loss, he lived with a brother on the reservation until 1968, where his brother could no longer keep him. Since admission to the nursing home ten years ago he has gone to blind school and spends many hours daily reading Braille. He spends a great deal of time out of doors also and has completely adjusted to nursing home life. His hearty laugh and ready wit make him a favorite of personnel and residents alike. If there were a foster home program for elderly on his reservation he could have returned long ago at considerable financial savings to the Bureau of Indian Affairs.

Case Study #8

Name	*Date of Birth*	*Tribe*	*Date Admitted to Nursing Home*
S.M.	1874	Papago	2/77

Diagnoses:
1) Supracondylar fracture of hip surgically repaired 1/77
2) Bilateral cataracts, nearly blind
3) Bilateral hearing loss, moderately severe
4) Diabetes mellitus
5) Anemia and chronic illness
6) Benign prostatic hypertrophy, recurrent urinary tract infections

This 104-year-old Papago male was placed in the nursing home following a hip fracture which made caring for him at home impossible. He has required re-hospitalization once in the past year for recurrent urinary tract infection, but has maintained his normal weight and basically good spirits in spite of his advanced age. He sits up two or three hours at a time and receives a great deal of attention from the nursing staff, many of whom speak his language. He does not appear to miss his home, perhaps because he is blind and nearly deaf.

APPENDIX B

GLOSSARY OF TERMS

angina pectoris—spasm of a portion of the heart muscle resulting in pain radiating from the heart to the left shoulder. Sometimes extends down the left arm.

cataract—a clouding of the lens of the eye causing a vision loss. Often associated with diabetes.

choleliathisis—formation of or presence of stones in the gallbladder or duct leading to the gallbladder. Interferes with digestion, particularly fatty foods.

chronic bronchitis—repeated inflamation of the tubes which lead from the trachea (windpipe) to the lungs.

cerebrovascular disease—blockage of the blood supply to a portion of the brain, or rupture of a blood vessel supplying the brain—"stroke".

cirrhosis of the liver—a degeneration of the tissue of the liver, usually due to heavy alcohol intake.

congestive heart failure—a complete condition with many causes most often characterized by a disproportion in the volume of blood on the "venous" side of the circulation compared to the arterial side. Often a complication of heart attacks or hypertension.

diabetes—inability or failure of the pancreas to produce the proper amount of insulin to use body sugar.

emphysema—a condition in which the tissues in the deep part of the longs becomes inelastic with resulting difficulty in breathing.

glaucoma—increased pressure within the eye that may result in blindness due to pressure on the nerve which supplies the eye.

hypertensive disease—"High blood pressure," "hypertension"

incidence—the number of new cases of an illness or condition appearing in a population during a specified time period.

infectious disease—a disease caused by invasions of a host, such as a human with a microorganism (i.e. "germ")

ischemic heart disease—heart disease caused by the obstruction of the blood supply to a part of the heart, i.e. "heart attack".

malignant—a condition which grows progressively worse, "cancer"

manic-depressive psychosis—a series of periods of psychotic depression or excessive well-being, alternating with longer periods of relative normalcy

morbidity—the state of being ill or diseased

myocardial infarction—reduction or blockage of the blood supply to a portion of the heart muscle—"heart attack" usually synonymous with "ischemic heart disease"

neoplasm—new formation of abnormal tissue

neurosis—a disease of the thought processes, i.e. anxiety, depression, hysteria, in which the personality structure of the individual usually remains unchanged

obesity—overweight

otitis media—inflamation of the middle ear. The persistence of this condition may result in hearing loss and even deafness.

parasitic disease—a disease caused by any organism that lives within, upon, or at the expense of another organism—"hookworm," "roundworm," "tapeworm".

peptic ulcer—ulcer of the stomach or duodenum.

personality disorder—a disorder characterized by deeply ingrained maladaptive patterns of behavior, i.e. anti-social, explosive, hysterical, paranoid personality.

pneumonia—a disease of the respiratory system in which the lungs become inflamed.

psychosis—mental disturbance in which there is a personality disintegration and loss of contact with reality, i.e. schizophrenia, manic-depressive.

schizophrenia—a psychotic state in which there are disturbances of thinking, mood, and behavior—there is an altered concept of reality—delusions and hallucinations may occur.

tuberculosis—an infectious disease caused by the invasion of the tubercle bacillus.

vagina—the external canal from the cervix to the outside of the body—the birth canal.

venereal disease—infectious disease caused by sexual intercourse with one having the condition—"syphilis" and "gonorrhea" are usually the most common.

viral disease—"measles," "smallpox," "chickenpox," "the common cold" and other contagious conditions.

APPENDIX C

DIABETES, OBESITY AND VASCULAR DISEASE IN ELDERLY INDIANS*

Diabetes is now a leading cause of disability and death in most tribes. In many tribes it is now the main health problem of people over forty years of age (West, 1974; 1978; 1978a). The extent and character of diabetes related problems differ among tribes in various parts of the country (West, 1974). In Alaska, for example, diabetes is not common in either Indians or Eskimos. But the frequency of diabetes is usually two to five times as great in Indians as in local whites. This increased prevalence of diabetes is seen in adults of all ages. The most frequent age of discovery of diabetes is in the 40's and 50's, but the highest rates of prevalence are in older Indians. In many tribes more than 20% of elderly Indians have diagnosed diabetes, and 10 to 20% have undiscovered diabetes (West, 1974; Bennett, 1976). If present trends continue a majority of Indians in many tribes will become diabetic at sometime before death (West, 1978a).

With good treatment most diabetics feel and look well. Indeed some diabetics live long lives, free of any serious effects of the disease. But long-term complications are becoming distressingly frequent (West, 1978; 1978a). These troubles are most frequently observed after 10 to 20 years of diabetes, although they may appear earlier.

In elderly diabetics, the most frequent problems caused by diabetes are heart disease, eye trouble, and gangrene of the feet requiring amputation. Heart disease is about twice as frequent in diabetics as in those without diabetes. Diabetes is the main cause of gangrene. Roughly 15% of Indian diabetics eventually have to have one or more amputations of the foot or leg. This trouble is largely confined to Indians over 40 years of age and is particularly common in those over 60. Cataract causing poor vision is about twice as common in old Indians with diabetes as in old Indians without diabetes. Deterioration of the retina (photographic plate at the back of the eye) is also common in older diabetic Indians. Treatment of this condition is not often effective in restoring vision. On the other hand, vision can usually be restored by surgery in diabetics with cataract. Diabetes often damages nerves, sometimes leading to weakness, paralysis, pain, or sexual impotence.

Diabetes problems of elderly Indians require a variety of different services, both treatment and preventive actions. A major difficulty is that the number of diabetics is now so great. This creates an almost overwhelming load on the doctors, nurses, dietitians, and other health workers who are trying to provide these services. One of the references (West, 1978) describes this overload problem and some possible solutions. Generally speaking, older diabetic Indians are receiving satisfactory care of their medical complications such as heart attacks, gangrene, or kidney failure. But the huge number of diabetics makes it very difficult to provide optimal preventive services (e.g., showing diabetics what to eat, how to care for the feet, how to test the urine, etc).

Another problem in many areas is that old Indians have difficulty reaching the stations where care is available. In comparison to younger Indians, they are less likely to drive or own automobiles. In many tribes, the elderly are less fluent in English. This makes it more difficult for them to learn the techniques required in caring for their diabetes. In elderly Indians, serious complications may occur before diabetes is discovered (e.g., gangrene).

These older diabetics are often made less mobile by the specific complications of diabetes such as impaired vision or heart trouble. In Oklahoma alone there are now more than 50 amputations every year for diabetic gangrene; a majority of these are in old people. There is great need for improved rehabilitation services for amputees. With better programs many who are disabled could be trained to walk again using artificial legs. More emphasis should be placed on prevention of gangrene through better care of the feet of elderly diabetics. The special diets given to older Indian diabetics are often insufficiently tailored to the special circumstances of Indian life and customs. Frequently those diets could be made less complex and more acceptable and feasible without great loss of therapeutic effectiveness. All these improvements are feasible, but they will require some new resources and new strategies. These are described more completely in one of the references (West, 1978).

The National Diabetes Board has recently recommended to Congress a special appropriation of 5 million dollars to help the Indian Health Service contend with the massive diabetes problem in Indians. This recommendation should receive enthusiastic support of the Indian people, particularly those with diabetics in the family. This latter group constitutes a majority of all Indians.

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* This article was prepared specially for this paper by Dr. Kelly M. West, University of Oklahoma, Health Science Center.

More research is needed on the causes of diabetes in Indians and on the causes of complications of diabetes. The National Institute of Health is sponsoring such research in both Arizona and Oklahoma Indians. The investigations in the Arizona Pimas have added much to the understanding of these problems and what to do about them (Bennett, et al., 1976). Studies in Oklahoma are more recent but they too have been informative (West, 1974; 1978a, 1978b). It has become clear that the main cause of the high rate of diabetes is the very great frequency of obesity. Prior to 1940 diabetes was uncommon in all tribes. Apparently this was because obesity of long duration was then uncommon. But now many Indians have been fat for 20 years or more, and diabetes has become much more common. Studies in the Pimas suggest that other factors are also important in causing diabetes in Indians (Bennett, et al., 1976). These include heredity. But the genetic mechanisms are incompletely understood and require further study.

Investigations in Oklahoma suggest that during the past three decades consumption of dietary fat has increased, with deleterious results. The high calorie regimen has probably enhanced susceptibility to obesity and diabetes. There is also evidence that these dietary changes have been attended with a substantial increase in heart disease. In Oklahoma Indians and most other tribes death rates from stroke and heart disease were formerly much lower than in whites (West, 1978; Sievers, 1968). But more recently rates of heart disease and stroke in Oklahoma Indians have closely approached those in whites. It seems likely that this is explained by higher levels of dietary fat, higher rates of obesity, and higher rates of diabetes in the Indians (West, 1978; 1978a, 1978b).

Studies in Oklahoma Plains Indians indicate that the old Indians were never as heavy as the present generation of middle-aged Indians (West, 1978). This suggests that in the future rates of diabetes will be even higher in elderly Indians.

In some respects diabetes is the leading health problem of elderly Indians. The toll from its major complications is increasing. These include particularly heart attack, stroke, gangrene, retinopathy (blindness), kidney failure, cataract, and nerve damage.

This epidemic of diabetes and its complications places a major burden on the limited resources of the Indian Health Service and the tribes. The National Diabetes Board has recently recommended to Congress that a special appropriation of 5 million dollars be made to the Indian Health Service to contend with these problems. This proposal deserves the support of the Indian people.

The main cause of the very high rates of diabetes is that Indians have become too fat. The cause of obesity is eating too much and exercising too little. Rates of diabetes in *lean* Indians are very low. Foods high in fat (such as fried foods) are also high in calories. They increase susceptibility to obesity, diabetes and heart disease.

This massive diabetes problem requires actions of several types. These include: 1) public education, (e.g., showing bad effects of obesity), 2) more and better preventive services (e.g., care of feet to prevent gangrene), 3) improved programs of detection (e.g., to discover and treat diabetes in the early stages), 4) better treatment programs (e.g., to decrease frequency of neuropathy, cataract, etc.), 5) improved rehabilitative services for those with disabling complications such as amputation or eye damage and, 6) research to find out more about what should be done to reduce the frequency of diabetes and each of the major complications. The Indian Health Service is working intensively and effectively in all these areas but the number of diabetics is now so great that there is an increasing disparity between the magnitude of the problem and the limited resources available.

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APPENDIX D

The Environment of Elderly Native Americans

American Indian Nurses Association*

EXECUTIVE SUMMARY

Environment for purposes of this background paper has been described as factors, including economic, social, and physical, that influence an elderly person's ability to remain in his own home and/or community. Since it is not possible in one paper to discuss all elements comprehensively, a selection of those most important in the Indian community has been made. These have been examined in terms of the impact on options an elderly person may or may not have for maintaining his independence or seeking semi- or completely protected living arrangements for health reasons.

The economic factors relate to income of the elderly and his family and the pressure that economic factors produce. The social factors relate to community services, including information and referral services and protective services for providing legal guardianships. The physical factors relate to public facilities and services, such as transportation and housing. The Indian family structure and other cultural considerations have been discussed as they relate to these factors. Because the family and community relationships are so important in the Indian community,[1] the independence and self-image of an elderly person has been interwoven in this report with community and cultural identity.

The services discussed concern living facilities, sanitation, transportation, nutrition, legal assistance, protection, recreation, culture, information and referral, tribal government, income, climate and a national clearing house. These areas were selected as the most important for the elderly Indian by the Professional Task Force.

Before these service areas are discussed, a review of health status of well elderly to sick and chronically ill elderly is provided. The services associated with various health levels are suggested.

Living facilities, including individual and congregate housing, are discussed in terms of design, cultural considerations, difficulties, and local control. The needs for maintenance, winterization, weatherization, and electrification are also mentioned. Nursing homes are briefly discussed for completeness.

Sanitation refers primarily to water availability and sewage disposal. The lack of water in some areas has limited the availability of proper sanitation facilities.

Transportation is important for obtaining both medical care and the necessities of life. When the elderly reside in a nursing home, temporarily or permanently, transportation for visitation is important. Road and weather conditions are also discussed. Without transportation, an elderly person can become trapped in his/her home and not have access to a full life.

Nutrition includes preparation of meals in the home, nutrition education, and group meal preparation sites. Nutritionally balanced meals and finances to provide them are discussed. The conflict between culture and nutrition are discussed.

Legal assistance for assisting in land and court problems is needed because of the dual legal system under which the elderly live. Assistance with wills, ownership problems and pension rights is also needed.

Protective services includes a variety of services ranging from home visitation to protection from abuse and neglect. The broader view of protective services which covers social, medical and legal services is discussed. Protection from abuse and isolation is needed.

Recreational facilities and services are important for the elderly. The need for recreation is very important especially for the well elderly. These activities can, in fact, facilitate the maintenance of culture, ceremonies and traditions.

Cultural factors are mentioned throughout the report. However, it was felt that special mention of land and family relationships was needed.

For the elderly person to match his need with resources, he must be aware of the services available. This is best accomplished by an information and referral organization. This can provide one entry point into the system.

Services for the elderly should be coordinated through one agency. This agency should be the tribal government in which the elderly are involved and in which they have confidence. The potential importance of inter-tribal organizations are also discussed.

Without an adequate income, many of the basic necessities of life cannot be secured. Data regarding the income level of the aging and aged Indian)45 years of age and older), percent of elderly Indians in labor force and unemployment rates for elderly are provided. These data highlight the economic plight and need for

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[1] Indian refers to American Indian and Alaska Native. Community refers to reservation, Indian communities, Indian villages, Alaska Natives land, pueblos, rancherias and urban centers.

better services for the elderly Indian.

Climate conditions which cause many of the hardships relating to housing, transportation and health are mentioned. How climate affects delivery of services is also discussed.

For each tribe to effectively use the experience of other tribes, a national clearing house should exist. The value of this service is discussed.

A major purpose of this paper is to outline service areas for the elderly Indian which can be used in developing the Tribal Specific Comprehensive Health Plans. By reviewing these services in total, the services required for the elderly Indian become apparent and may be funded under P.L. 94-437.

One of the other important physical factors, availability of medical facilities and health services, has been addressed in the background paper on services required for a continuum of care. The physical and mental health status of elderly Indians has been described in separate papers.

INTRODUCTION

Fifty years ago (1928), the Meriam Report[1] on the problem of American Indians was published. This report stressed the importance of accepting and valuing the cultural uniqueness of the first Americans. This implied that any solution to problems of the elderly Indian must be based on their uniqueness, culture, and living environment. The solutions will require the involvement of all Indian groups. This includes the young tribal members, local tribal governments, and national tribal organizations.

This paper must be read with a historic perspective. It deals with a portion of a complex problem with the hope that the reader can put together the interrelationships with other efforts that involve the elderly Indians. The relationships between social policy and social research as it impacts upon the physical environment of the elderly American Indian is addressed.

The land that comprises the Indian Reservations is vast. There are over 90 million acres of land,[2] 100,000 miles of roads,[3] and public buildings and private housing unique in America.[4] The land which is important to the Indian people has all types of landscapes.[5] The land is an integral part of the Indian culture and customs. It is essential to the tribes because it contains the memories of the past which are transmitted to the young generations. The land is filled with history, conflicts and struggles.

Some of the reservations only have a few acres, others could harbor a full state, such as the Navajo Reservation with 14 million acres of land. Figure 1 displays the reservation areas. Additionally, the people on each reservation have a unique culture, language, customs and life style.

The most important part of the environment is the people with their repository and memory of all loved traditions. Chino, Chairman of the Mescalero Apache Tribe said:

> the elderly Indian, down through the years, has been the preserver of the Indian race, Indian culture, Indian history... they represent a repository.[6]

The number of elderly people living on the reservation in 1970 is contained in Table 1. This information is provided for the age groups 45 to 64 and 65 and over.

Table 2 indicates the Indian population of the United States in five-year age groups starting with age 45 for males, females and total. This gives a feeling for the number of people potentially affected by this report as of 1970.

Table 3 contains an estimate of the number of aging and aged people as of 1980 on the reservations. This indicates there will be 130,626 elderly Indians in 1980 on the reservation 45 years of age and older.

Table 4 gives an indication of traditional cultural ties. The table concerns the number of elderly Indians who speak a mother tongue.

This paper is about a specific and unique society of elderly Indians which are within a specific and different world from the more general culture in the U.S. The physical environment is a major part of their uniqueness. The Indians believe that harmony must be maintained between the spirit and the earth. This belief is consistent with improving the housing, and transportation system available to the elderly. In this change, care must be taken not to harm the family and community ties that are so important to the elderly Indian and his culture.

The physical environment should be improved so that the elderly Indian can remain in his own home. However, if this is not possible, then alternative living arrangements should be available in the local com-

[1] Lewis Meriam and Associates, "The Problem of Indian Administration" (Baltimore: Institute for Government Research, Johns Hopkins Press, 1928).

[2] "The American Indians, Answers of 101 Questions," United States Department of the Interior, Bureau of Indian Affairs, Inc., 1974, U.S. Government Printing Office, Washington, D.C. (Stock Number 2402-00040), p. 13.

[3] Ibid., p. 17.

[4] "Pueblo Poverty Fails to Dim Love to the Ancestral Mesa," Lacey Fosburgh, **The New York Times**, Sunday, February 7, 1978.

[5] Laura Gilpin, "The Enduring Navajo," University of Texas Press, Austin and London, 1968.

[6] From the opening remarks of Wendell Chino, in Summary Report, National Indian Conference on Aging, Phoenix, Arizona, June 15-17, 1976, p. i., National Tribal Chairmen's Association, Inc.

FEDERAL INDIAN RESERVATIONS

Figure 1

NEVADA

1 ELKO
2 SOUTH FORK
3 RUBY VALLEY
4 RODGERS RANCH
5 ELY
6 DUCKWATER
7 YERINGTON
8 RENO-SPARKS
9 BATTLE MOUNTAIN
10 WINNEMUCCA
11 SUMMIT LAKE
12 MOAPA
13 LAS VEGAS

ARIZONA

1 CAMP VERDE
2 FT MCDOWELL
3 SALT RIVER
4 PRESCOTT YAVAPAI
5 PAYSON TONTO APACHE

CALIFORNIA

(85 RANCHERIAS IN CALIFORNIA NOT SHOWN DUE TO REDUCED SCALE OF MAP.)

WASHINGTON

15 ADDITIONAL TRIBES NOT SHOWN DUE TO SPACE LIMITATIONS

TABLE 1

Indian Population for 45 Years of Age and Over on Identified Reservations, 1970

Reservations	Population		Sex			
	Number	Percent	Male	Female	45 to 64	65 and over
Total on identified reservations	**213,770**	**100.0**	**105,185**	**108,585**	**25,783**	**11,853**
Acoma (Acomita), New Mexico	1,590	0.7	727	863	224	83
Allegany, New York	746	0.3	333	413	174	75
Allen Canyon, Utah	1,157	0.5	547	610	100	32
Bad River, Wisconsin	575	0.3	297	278	106	27
Big Cypress Seminole, Florida	203	0.1	108	95	26	13
Blackfeet, Montana	4,757	2.2	2,435	2,322	630	237
Brighton Seminole, Florida	358	0.2	173	185	44	23
Canoncito, New Mexico	851	0.4	364	487	86	5
Cattaraugus, New York	942	0.4	441	501	189	115
Cherokee, North Carolina	3,455	1.6	1,751	1,704	489	188
Cheyenne River, South Dakota	3,440	1.6	1,710	1,730	373	186
Cochiti, New Mexico	439	0.2	207	232	62	50
Coeur d'Alene, Idaho	367	0.2	184	183	22	43
Colorado River, Arizona-California	1,715	0.8	904	811	240	74
In Arizona	1,715	0.8	904	811	240	74
In California	—	—	—	—	—	—
Colville, Washington	1,417	0.7	767	650	209	109
Crow, Montana	3,049	1.4	1,493	1,556	329	95
Crow Creek, South Dakota	973	0.5	456	517	118	46
Duck Valley, Idaho-Nevada	773	0.4	390	383	127	65
In Idaho	157	0.1	95	62	30	15
In Nevada	616	0.3	295	321	97	50
Flathead, Montana	2,537	1.2	1,346	1,191	319	243
Fond du Lac, Minnesota	391	0.2	240	151	27	41
Fort Apache, Arizona	5,903	2.8	3,009	2,894	655	187
Fort Belknap, Montana	1,111	0.5	568	543	121	72
Fort Berthold, North Dakota	1,032	0.5	495	537	164	57
Fort Hall, Idaho	1,641	0.8	836	805	199	104
Fort McDowell, Arizona	152	0.1	69	83	21	21
Fort Peck, Montana	3,182	1.5	1,560	1,622	381	186
Fort Totten, North Dakota	1,552	0.7	781	771	206	78
Fort Yuma, California	565	0.3	280	285	53	60
Gila River, Arizona	4,573	2.1	2,292	2,281	544	314
Grand Portage, Minnesota	83	—	46	37	34	5
Greater Leech Lake, Minnesota	1,985	0.9	994	991	278	145
Hoopa Valley, California	838	0.4	411	427	149	43
Hopi, Arizona	4,404	2.1	2,097	2,307	596	357
Hualapai, Arizona	443	0.2	244	199	77	31
Indian Township Passamaquoddy, Maine	212	0.1	95	117	7	11
Isleta, New Mexico	1,604	0.8	776	828	202	89
Jemez, New Mexico	1,052	0.5	536	516	143	93
Jicarilla, New Mexico	1,332	0.6	673	659	128	47
Joint Use Area (Navajo and Hopi), Arizona	7,726	3.6	3,639	4,087	798	303
Kaibab, Arizona	83	—	29	54	12	—
Lac Courte Oreilles, Wisconsin	767	0.4	361	406	115	63
Lac du Flambeau, Wisconsin	848	0.4	410	438	116	27
Laguna, New Mexico	2,579	1.2	1,242	1,337	433	188
Lower Brule, South Dakota	552	0.3	273	279	74	31
Lummi, Washington	651	0.3	348	303	39	35
Makah, Washington	443	0.2	208	235	73	13
Maricopa, Arizona	376	0.2	173	203	39	7
Menominee, Wisconsin	2,445	1.1	1,232	1,213	377	91
Mescalero, New Mexico	1,556	0.7	754	802	173	77
Mille Lac, Minnesota	303	0.1	133	170	99	12
Nambe, New Mexico	92	—	44	48	13	19
Navajo, Arizona-New Mexico-Utah	56,949	26.6	27,317	29,632	5,986	2,489

TABLE 1 (continued)

Reservations	Population		Sex			
	Number	Percent	Male	Female	45 to 64	65 and over
In Arizona	36,999	17.3	18,013	18,986	3,796	1,643
In New Mexico	17,700	8.3	8,240	9,460	1,990	781
In Utah	2,250	1.1	1,064	1,186	200	65
Nett Lake, Minnesota	250	0.1	137	113	44	25
Nez Perce, Idaho	947	0.4	456	491	105	67
Northern Cheyenne, Montana	2,357	1.1	1,102	1,255	306	72
Omaha, Nebraska	1,195	0.6	587	608	159	54
Oneida, Wisconsin	1,642	0.8	825	817	228	121
Onondaga, New York	752	0.4	363	389	78	41
Papago, Arizona	4,879	2.3	2,482	2,397	760	437
Penobscot, Maine	299	0.1	144	155	62	5
Picuris, New Mexico	65	—	21	44	12	7
Pine Ridge, South Dakota	8,280	3.9	4,111	4,169	988	524
Point Pleasant, Maine	240	0.1	143	97	41	30
Pojoaque, New Mexico	33	—	19	14	—	—
Potawatomi, Kansas	146	0.1	77	69	16	40
Potawatomi, Wisconsin	173	0.1	108	65	13	—
Puertocito, New Mexico	500	0.2	251	249	58	23
Pyramid Lake, Nevada	425	0.2	250	175	52	68
Quinault, Washington	639	0.3	340	299	26	60
Ramah, New Mexico	847	0.4	436	411	123	5
Red Cliff, Wisconsin	178	0.1	91	87	61	—
Red Lake, Minnesota	2,741	1.3	1,357	1,384	290	128
Rocky Boys, Montana	1,095	0.5	541	554	89	42
Rosebud, South Dakota	5,656	2.6	2,840	2,816	711	307
Round Valley, California	296	0.1	143	153	74	20
Sac and Fox, Iowa	422	0.2	208	214	76	13
Saint Regis, New York	1,199	0.6	651	548	214	98
Salt River, Arizona	721	0.3	438	283	52	55
Sandia, New Mexico	162	0.1	65	97	31	28
San Carlos, Arizona	4,525	2.1	2,172	2,353	423	224
San Felipe, New Mexico	1,366	0.6	680	686	149	45
San Ildefonso, New Mexico	296	0.1	167	129	18	21
San Juan, New Mexico	547	0.3	257	290	64	40
San Xavier, Arizona	493	0.2	228	265	82	61
Santa Ana, New Mexico	255	0.1	108	147	23	8
Santa Clara, New Mexico	674	0.3	272	402	94	42
Santo Domingo, New Mexico	1,578	0.7	777	801	210	114
Shinnecock, New York	129	0.1	69	60	36	30
Sisseton, North Dakota-South Dakota	1,768	0.8	798	970	178	86
In North Dakota	—	—	—	—	—	—
In South Dakota	1,768	0.8	798	970	178	86
Skokomish, Washington	100	—	60	40	6	11
Southern Ute, Colorado	611	0.3	346	265	46	33
Spokane, Washington	559	0.3	311	248	75	39
Standing Rock, North Dakota-South Dakota	2,925	1.4	1,441	1,484	436	183
In North Dakota	1,498	0.7	714	784	249	72
In South Dakota	1,427	0.7	727	700	187	111
Stockbridge, Wisconsin	138	0.1	60	78	18	21
Swinomish, Washington	214	0.1	105	109	47	9
Taos, New Mexico	720	0.3	342	378	108	113
Tesuque, New Mexico	225	0.1	130	95	24	34
Tonawanda, New York	435	0.2	202	233	91	38
Tulalip, Washington	352	0.2	207	145	25	38
Tule River, California	122	0.1	63	59	13	—
Turtle Mountain, North Dakota	3,386	1.6	1,701	1,685	404	247
Tuscarora, New York	744	0.3	423	321	130	40
Uintah and Ouray, Utah	1,430	0.7	691	739	94	91
Umatilla, Oregon	525	0.2	241	284	92	28
Ute Mountain, Colorado-New Mexico	730	0.3	398	332	98	82
In Colorado	730	0.3	398	332	98	82
In New Mexico	—	—	—	—	—	—

TABLE 1 (continued)

Reservations	Population		Sex			
	Number	Percent	Male	Female	45 to 64	65 and over
Vermillion Lake, Minnesota	39	—	25	14	12	—
Walker River, Nevada	371	0.2	189	182	28	19
Warm Springs, Oregon	1,428	0.7	665	763	172	67
White Earth, Minnesota	1,474	0.7	718	756	196	166
Wind River, Wyoming	3,319	1.6	1.704	1,615	386	152
Winnebago, Nebraska	601	0.3	295	306	89	41
Yakima, Washington	2,509	1.2	1,165	1,344	373	93
Yankton, South Dakota	798	0.4	383	415	143	93
Zia, New Mexico	448	0.2	199	249	42	27
Zuni, New Mexico	4,736	2.2	2,358	2,378	480	242
Other	292	0.1	251	41	10	—
Not on identified reservations	549,824	...	270,199	279,625	78,968	31,949

SOURCE: U.S. Department of Commerce, United States of America.

TABLE 2

Distribution of Indian Population by Age and Sex in the United States, 1970

Age	*Combined*	*Male*	*Female*
45-49 years	31,822	15,337	16,485
50-54 years	27,922	13,300	14,622
55-59 years	24,986	11,627	13,359
60-64 years	20,021	9,558	10,463
64-69 years	17,239	8,242	8,997
70-74 years	11,121	5,260	5,861
75-79 years	7,468	3,507	3,961
80-84 years	4,234	2,037	2,197
85 years and over	3,740	1,656	2,084
Total	148,553	70,524	78,029
62 years and over	55,607	26,314	29,293
65 years and over	43,802	20,702	23,100

1970—Census of Population—U.S. Department of Commerce—United States of America. Final Report PG(2)-1F American Indians—Table 2, page 2.

TABLE 3

Indian Health Service 1980 Population Estimates for 45 Years of Age and Over Using 1970 Distributions

Age Group	*Number*	*1970 % Distribution*
45-64	86,970	13.0
65+	40,041	6.0
85+	3,615	.5

Source: Population Branch, Office of Program Statistics, Indian Health Service, Oct. 1977.

TABLE 4

Number of Elderly Indians Speaking Mother Tongue in U.S.

	45-64	*65 and over*
All Indians	104,459	43,635
Speaking mother tongue	36,518	15,851
Percent	35%	36%

Source: 1970 Census of Population, U.S. Department of Commerce, United States of America. Final Report PG(2)-1F American Indians, Table 18, page 192.

munity to provide the level of care/support required.

Another part of the environment is the social needs of the elderly. This includes the coordination of resources.

The economic factors relate to ability to secure needed goods and services, both from an individual's income and a tribal income viewpoint.

Two important concepts will be useful in reading the various sections on the environment. The first concerns living arrangement and the second are services required for various levels of individual health. These two concepts are interwoven and depend upon each other. In the selection of services, including living arrangements, the individual must have a choice. The choice will allow the individual to match his needs with the community resources. The four levels of living arrangements are: independent, limited support, intermediate support, and skilled support. The following discuss each one and related services:

a. Independent

Characterized by individuals who are completely self-sufficient. The apparently well adult, who lives independently, may use limited resources which are mostly for social activities. The services that could be provided include:

—legal services
—nutritional programs
—recreation and/or social activities
—senior citizen center
—religious services
—ombudsman
—traditional activities
—winterization, heating and cooling repairs
—transportation - escort services
- shopping services

b. Limited support: In Home

Characterized by one who remains at home, supervised in shared living; who remain at home because of support services provided by relatives or kinship groups and occasionally by non-relatives, professionals, or non-professional personnel. The following services can be supplemented to the elderly:

—telephone reassurance
—friendly visiting service
—home-delivered meals
—home-repair services
—legal services
—nutritional programs
—recreation and/or social activities
—senior citizen centers
—public health nurse services
—traditional activities
—social work services
—winterization, heating and cooling repairs
—transportation - escort services
- shopping services

c. Intermediate support: Boarding Home or Day Care Center

Characterized by a protective living environment other than the individual's home with limited medical attention as needed. However, personal care services to assist a person in activities of daily living are available at all times.

—ombudsman
—meals
—personal care services
—legal services
—social services
—public health nurse services
—traditional activities
—transportation - escort services
- shopping services

d. Skilled support: Institutional

Characterized by long-term stay with 24-hour nursing care.

—nursing homes - (SNF) skilled nursing facility
- (ICF) intermediate care facilities

These four alternative physical environments can be discussed in terms of cost.[1-5] The more limited the support (independent), the lower the facility cost but the more staff required because of the large number of people served. As the level of care increases (skilled), the greater the facility cost but the lower the staff cost because of fewer people being served. Figure 2 displays this relationship.

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[1]The Report of the Task Force, "The Future of Long-Term Care in the United States," U.S. Dept. of H.E.W., Public Health Service, Health Resources Administration, National Conference on Social Welfare, Washington, D.C., February 1977.

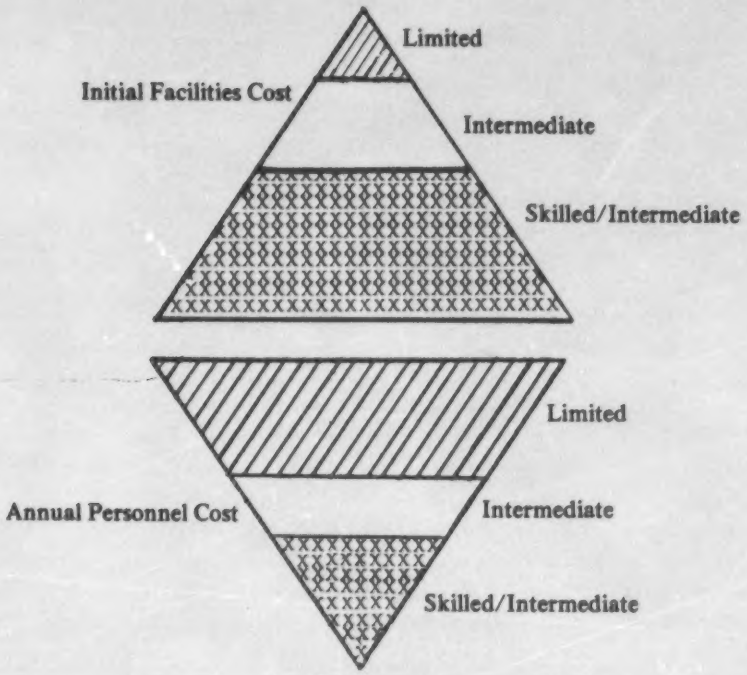
[2]S.J. Brody and E. Cohen, "Broad Social Issues," in **A Social Work Guide for Long-Term Care Facilities**, by Elaine Brody, et al. National Institute of Mental Health, Washington, D.C., 1974.

[3]"Report of Governor's Commission on Nursing Homes," Baltimore, Maryland, Governor's Commission on Nursing Homes, 1973.

[4]National Center for Health Statistics: Home Care for Persons 55 Years and Over, United States, July 1966-June 1968. Vital and Health Statistics, Series 10, No. 73, Dept. of HEW, Publication No. (HRS) 72-1062, U.S. Government Printing Office, 1969.

[5]M.W. Riley, J.W. Riley and M.E. Johnson, "Aging and Society." Vol. 2, "Aging and the Professions," New York, Russell Sage Foundation, 1969.

Figure 2
Initial Facility Cost and Annual Personnel Cost



Source: Provider Task Force on Environmental Factors of the Indian Elderly, March 1978

As a person ages, his physical and mental condition declines. In relationship to the environment, the ability to sense, hear, taste, smell, touch, and differentiate colors and brightness change.[1-5]

In a broad scheme, the elderly's physical environment can be divided into three major types of services needed. The services relate to the level of physical health: well, frail/fragile; and sick/chronically ill. This classification is important for planners at the local level because it shows the complexities in providing a comprehensive program for the elderly with various levels of health.

Figure 3 represents services, all of which—may not be appropriate at this time but which may be in the future for various levels of health.

The amount of support services to maintain the individual in his own home is expected to be lower for the well elderly than the sick elderly person. The ideal is to have an array of services to meet all levels of need so that a continuity of care is available and appropriate to a given individual's requirements. Figure 3 indicates that array of services.

The remainder of this paper will focus on services that are best described by the following headings:

1. living facilities
2. sanitation
3. transportation
4. nutrition
5. legal issues
6. protective services
7. recreation services
8. culture
9. information and referral service
10. tribal government
11. income
12. climate
13. clearing house

These services will not represent every possibility, but are only a basis for consideration of what services should be available to the elderly Indian.

[1]A. Chapanis, "Relationship Between Age, Visual Acuity and Color Vision," **Human Biology**, 22:1-33, 1950.

[2]J.F. Corso, "Sensory Processes and Age Effects of Age in Taste Sensitivity," **Journal of Gerontology**, 14:56-58, 1959.

[3]E. Palmore and F.C. Jeffers (eds), **Prediction of Life Span**, Lexington, Massachusetts, D.C. Heath Co., 1971.

[4]E. Palmore, "Physical, Mental and Social Factors in Predicting Longevity," **Gerontologist**, 9:103-108, 1969.

[5]L.H. Snyder, "Behavioral Goals in the Design and Program Planning of Facility for Older Persons." Unpublished material correspondence with Jack L. Bowersox, February 1978.

Figure 3

Necessary Services

Continuum of Services

Well	*Frail/Fragile*	*Sick and Chronically Ill (Impaired)*
Housing appropriate	Housing appropriate	Housing appropriate
General assistance	General assistance	General assistance
Retirement information	Retirement information	Retirement information
Home repairs and maintenance	Home repairs and maintenance	Home repairs and maintenance
Day care	Day care	Day care
Transportation Shopping centers for food, clothing, recreation, health care, visitation	Transportation	Transportation
Food stamps	Food stamps	Food stamps
Nutrition Ethnic foods	Nutrition Ethnic foods	Nutrition Ethnic foods
Home-delivered	Home-delivered meals	Home-delivered meals
Congregate meals Reservation/community meal service (Reservation	Congregate meals Reservation/community meal service (Reservation)	
	Home health aide/ homemaker	Home health aide/ homemaker
Protective services: Friendly visitor Guardianship Consumer protection	Protective services: Guardianship Consumer protection Protective services	Protective services: Friendly visitor Consumer protection Protective services
Health services Dental, podiatry eye, hearing	Health services Dental, podiatry eye, hearing	Health services Dental, podiatry eye, hearing
Preventive health and maintenance services: Preventive health maintenance clinics	Preventive health, maintenance, care and rehabilitative services: Home health services Health maintenance clinics Home health agencies	Preventive health maintenance, care and rehabilitative services: Home health agencies Custodial care facilities Skilled nursing care facilities
Information referral	Information referral	Information referral
Telephone service	Telephone service	Telephone service
Recreation services	Vacation relief for families Recreation Services Social Services	Vacation relief for families Recreation Services Social Services
	Utilization of community health/ social organizations such as Cancer Society, Lung Association, Heart Association, Ombudsman	Utilization of community health/ social organizations such as Cancer Society, Lung Association, Heart Association, Ombudsman

LIVING FACILITIES

Living facilities refer to an individual's family home, special housing for the elderly, group living facilities and nursing homes or rehabilitation centers. Reference to programs in various types of homes will be made. The concerns of winterization, electricity, and home repairs and maintenance will also be discussed.

To understand living facilities for the elderly Indian, the importance of the extended family must be remembered. Many elderly Indians would not consider living without their children and grandchildren. The elderly live and prefer to live in the more traditional settings. When the young adults go off into the more urban areas for employment, the elderly face a conflict over leaving their land or not being with their children. In the following discussion, the duel importance of the extended family and land must be remembered.

The concept of elderly housing has been broadened; the effort is to provide a variety of choices from which the older person can select the one most suited to individual needs and preferences. Facilities should be designed to respond to local and cultural differences and requirements. At present, Anglo design approaches and values have been, for the most part, imposed on Indians in programs where funding and control rested in Anglo hands. This practice is widely prevalent, even with the Self-Determination Act (P.L. 93-638) and the establishment of numerous tribal housing authorities since 1973. This trend should favor Indian control and future designs that fit the cultural uniqueness of the Indian physical environment. The existing choices must be broadened and the elderly should be consulted about exterior and interior design features of new community facilities planned to meet their needs.

Choices should include:

1. long-term care facilities close to where the people live;
2. congregate housing which would provide food and personal service but not medical care service; and
3. housing with recreational activity areas for totally independent living.

Housing would be more available with the elimination of the present requirements of "credit worthy requirements" to get federal housing.[1] Otherwise, due to lack of funds, the efforts will have little impact due to dimensions of the housing problem on the

[1] A Self-Help Housing Process for American Indians and Alaskan Natives, prepared by the Organization for Social and Technical Innovation, Inc. and the Association on American Indian Affairs, December 1966.

reservations.[1-2]

The cultures and traditions of the Indian must be resolved with the federal requirements. This lack of coordination can only be minimized when the local housing authorities increase their influence over the many organizations involved.[3] There is also a need for some systematic effort to determine with the elderly Indian the unmet needs and cultural obstacles.

Examples of the potential design modifications to current regulations are:

1. Settings should allow for walks of varying lengths, with places for resting.
2. Food preparation and nutrition must be facilitated by proper design, such as individual kitchens planned for ease of movement and food preparation, food storage and meal serving.
3. Multipurpose community room should accommodate larger group meals.
4. Appropriate space should be allocated for personal hygiene and other activities of daily living.
5. Space should be planned in the bedrooms to allow the individual to make his/her own bed without undue stress or strain.
6. Adequate resting places should be incorporated in the facility design.
7. Windows should be easy to operate to enable tenants to air their dwelling.

The ultimate goal is to provide older Indian persons with the environment that would maintain a personally meaningful life in a setting which facilitates individual objectives and allows for personal growth.

As can be seen in Table 5, a larger percentage of Indians rents than does the total general population. In addition, homes occupied by Indians have less indoor plumbing and more occupants per dwelling. These data apply to all Indians. Since the elderly live in more traditional settings, they are likely to be the population group accounting for these differences.

Progress with new public housing and renovation through the installation of basic water and sewage systems face the following constraints that must be discussed and acted upon:

1. The high cost of low-rent housing.
2. The long construction time.
3. The failure of universal qualifications in the establishment of housing authorities, regardless of the size on the reservation.
4. The desire of the federal agencies to maintain Anglo standards of quality without regard to the cultural specificities of the Indian.
5. The high percentage of renters, which does not stimulate appropriate care and maintenance (see Table 5).

TABLE 5

Selected Characteristics of Indian Housing, 1970 (percentage)*

	U.S.	*Indian*
Percent Renter	37.1	50.0
Percent without plumbing	5.5	26.3
Percent with 7 or more persons	5.1	15.7

* Indian Housing in the United States, A Staff Report on the Indian Housing Effort in the United States with Selected Appendices, Committee on Interior and Insular Affairs, Washington, D.C.: U.S. Government Printing Office, February 1975, p. 2.

The types of housing that can be built ranges from single to multiple dwelling units. Other approaches include building multi-purpose centers, including space for housing the well and impaired aged with activity areas planned for other age groups; one example of this approach is the project being undertaken by the Laguna Pueblo. It provides more of an extended family concept and adds to the culture. Where such multi-purpose center includes a child care center, this would provide an opportunity for elders to teach and care for the children.

If nursing homes are built, they should be near the home community of the older person so he can stay in touch with family and friends. The designs must also take into account the social, cultural, emotional, and physical needs of the elderly.

Equally important to housing construction are home repair and maintenance, winterization, and weatherization of homes, and electricity. In many

[1] Task Force on Indian Housing, "Indian Housing: Need, Alternatives, Priorities and Program Recommendations," Bureau of Indian Affairs, December 1966.

[2] Indian Housing in the United States, A Staff Report on the Indian Housing Effort in the U.S., with selected appendices, Committee on Interior and Insular Affairs, Washington, D.C.: U.S. Government Printing Office, February 1975.

[3] The supplier or guarantor of funds generally is the Department of Housing and Urban Development, Housing Assistance Administration (HUD, HAA), but may also be the Farmers Home Administration (FmHA); HUD, Federal Housing Administration (HUD, FHA); Veterans Administration (VA); or the Department of the Interior, Bureau of Indian Affairs (DOI, BIA). The builder of roads is generally DOI, BIA, but may be HUD, HAA; and the supplier of water and sewage facilities generally is the Department of Health, Education, and Welfare, Indian Health Services (DHEW, IHS) and may be HUD, HAA.

cases, an older person could stay in his own home if it were improved and maintenance were provided. Such assistance would make homes safer and healthier for older persons who are not physically or financially able to improve their own homes.

Electricity is important for the elderly Indian. Not having electricity is a hardship for the elderly, because this means that refrigeration is not available for preserving and storing food. Lack of available electricity limits recreation, such as listening to radio and viewing television as well as the physical comforts of lights, fans, etc., which most people consider to be basic necessities of living.

Although outside the area of living facilities, senior citizens centers and day care centers provide for social and recreational opportunities. They serve the dual purpose of providing support services and a constructive means of helping the elderly maintain customs of the culture. There can be several kinds of day care centers that would provide the maximum benefits for elderly. One is a community day care center for children but where the elderly can assist in caring of and teaching the young. A second is visitation day care service where outreach workers can call on the elderly to assist in their needs and problems. A third is day care facilities where the aging without the lack of care or companionship can spend the entire day or stay overnight for short periods of time. These facilities should be built near tribal gathering places (chapter houses) and utilize tribal resources for maximum benefit and reduced transportation problems.

Self-determination and control at the local level are the only guarantee that the designs chosen and programs offered will reflect the priorities of the community with its local needs, climate, and physical terrain.

Codes, standards and regulations for construction must allow the maximum feasible participation of the community in setting the parameters that in the end will be used by the people themselves.[1]

SANITATION

Sanitation as discussed here is primarily related to water availability and outdoor toilets. In many reservation areas, water is not available. In the Pinon and Rough Rock areas on the Navajo Reservation, for example, water must be hauled 30 miles.

Many homes do not have indoor toilets. Table 5 indicates, as of 1970, that 26.3% of Indian housing units are without plumbing. This compares with only 5.5% of housing for the general U.S. population. Table 6 indicates that the number of Indian homes with complete bathrooms is lower for rural areas than urban areas (50% versus 91%). For a home to have an indoor toilet there must be piped water. Table 6 indicates that almost all Indian homes in urban areas have pipe water while a third of the rural Indian homes are without piped water. As stated before, the elderly Indians tend to live in traditional homes and their homes represent a large percent of the homes without indoor toilets. The addition of outdoor toilets would greatly improve the sanitation conditions in many rural or reservation areas where the population is too sparse to permit water and sewer connection to a community system or other environmental factors make installation of septic tanks difficult or impractical.

TABLE 6

Selected Equipment Characteristics of Indian Households by Urban and Rural Residence: 1970

	Total U.S.	*Urban U.S.*	*Rural Non-Farm U.S.*	*Rural Farm U.S.*
Total households	180,849	91,860	79,605	9,384
With complete bathrooms	130,237	83,964	41,954	4,319
With more than 1 bathroom	19,289	14,645	4,057	587
With piped water in the building	150,955	90,995	54,410	5,550
With public water supply	125,815	89,015	35,566	1,234
With public sewer	104,385	83,355	20,650	380

Source: U.S. Department of Commerce, Social and Economic Statistics Administration, Bureau of Census, Subject Report: American Indian PC(2) - 1F - Table 10.

TRANSPORTATION

Transportation could be considered the top priority for all Indian programs. No one likes to be trapped in one room in an urban environment or restricted to their home on the reservation. Without transportation, food and supplies cannot be obtained in our modern society. Medical care, except perhaps Home Health Care Programs, is not reachable.

Without some transportation system on the reservation, all efforts to maintain the elderly in their community will be seriously limited.

[1] Wolfgang F.E. Preiser, ed. **Facility Programming: New Concepts and Approaches**, Stroudsburg, Pa.: Dowden, Hutchinson and Ross, 1978.

Without transportation the elderly Indian cannot acquire those necessities which would assure him a normal and healthy life.

There is a need for the construction and improving of roads.

Many elderly are not in a position to drive or own a vehicle for their own transportation.

Funds should be allocated to assure all elderly American Indians of their transportation needs.[1]

There is a need for additional vehicles, mileage allowances, fuel and personnel to operate transportation services both on and outside the reservation.

At present, many reservations have inadequate transportation systems. The condition of the roads are similar to the underdeveloped regions of the world.[2] During the 50's, many roads on reservations were transferred to the counties and States through "take-over" agreements. These agreements provided that, when roads were built by the Bureau of Indian Affairs, the county or State would be responsible for their future maintenance. Today the States are responsible for maintenance for approximately one-half of the roads.

The problem with unpaved roads is that they may become impassable in winter, when an area has extensive snow. If an area receives heavy rains, the unpaved roads turn into mud. On all but the main highways on the Navajo Reservation, for example, the snow and mud limits transportation about six months out of the year.

There is a fear among Indians, however, that more roads will harm their traditional way of life by bringing industry. This is one reason for not enlarging the transportation system. In the past, the development of highways and railroads contributed to the loss of Indian land.

The lack of a better transportation system is a constraint also against industrial development since industries need an easy way to obtain raw materials and distribute their products to outside markets.[3-5]

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[1] 1971 White House Conference on Aging—Recommended for Actions the Elderly Indians, U.S. Government Printing Office, Washington, D.C., 1971, Report of the Special Concerns Session on the Elderly Indian, p. 5.

[2] U.S. Bureau of Indian Affairs, Branch of Roads, "Indian Reservation Roads," 1967, p. 2.

[3] Keith L. Fay, "Developing Indian Employment Opportunities," U.S. Department of the Interior, Bureau of Indian Affairs, 1972.

[4] J. Murray, "Industrial Development on Indian Reservations, Upper Midwest," Moorhead, Minnesota: The Upper Midwest Research and Development Council, 1969.

[5] "A New Seal Coming for American Indians," **U.S. News and World Report**, September 14, 1970.

NUTRITION

Nutrition is a concern of every individual. Due to an inability of the elderly Indian to obtain his food by traditional means, i.e., hunting and ranching, nutrition becomes of paramount importance. His ability to obtain the essential nutrients for good health are limited by lack of income, education and available resources.

The main challenge is to provide good nutrition while not losing sight of the individual's taste and cultural uniqueness. Each tribe has its own specific food patterns and habits which have sustained the people for generations. It has only been since foods, such as soft drinks, concentrated sweets, potato chips, etc., of the non-Indian population have been adopted that the overall nutritional status of Native Americans has deteriorated. Concommitantly, the aged are not aware and/or not able to participate successfully in food assistance programs.

In general, Indian elderly subsist on diets high in carbohydrates, fats and salt and low in protein, vitamins and minerals. This type of dietary intake produces a number of nutrition-related diseases: obesity, diabetes, gallbladder disorders, hypertension and dental diseases.

Nutritional problems are compounded by a cluster of adverse conditions under which many Indian elderly live. Inadequate or non-existent sanitary facilities, lack of storage and conventional utilities, geographic isolation, lack of transportation, and low or no incomes are, for example, factors contributing to the overall problems. There should be a mandate to provide each elderly Indian the foods necessary to satisfy the Recommended Dietary Allowances (RDA's) of the Food and Nutrition Board, National Research Council, within the context of his cultural food patterns. This effort should be administered at the local level where the needs, manpower, physical requirements, native staff and administration are known. At this level nutrition and social service programs can be coordinated. These would include federal, state and local funding agencies concerned with food stamps; family food distribution; welfare; social security; Title III and VII of the Older Americans Act, as well as private sources. In general, there is a need for additional nutrition education programs to supplement Title VII Congregate Feeding programs on reservations.

Some programs that are successful in urban areas are not conducive to reservations, such as Meals-On-Wheels. Congregate meal sites have been used but not all elderly can be served. They either lack transportation or are home bound. Vast distances preclude a feasible Meals-On-Wheels project. Inadequate funding is another deterrent for the elderly Indian population

receiving adequate food to maintain balanced nutrition. Realistically, one meal a day, five days a week does not meet accepted norms.

In any food program, a nutrition education component should be available to teach people what they should eat and how to prepare the food in order to maintain health. Studies have shown that education is more effective if provided by members from the same cultural background.

For an individual who can manage his own household, assistance is indicated to help purchase and obtain necessary foods. The food stamp or family food distribution programs should be made known and available to these individuals. Special consideration should be made to compensate for the higher food prices at trading posts or for those families lacking access to shopping facilities in cities.

There also exists a need for a viable outreach and ombudsman program to inform the elderly of all programs and to assist them in participating actively in the pursuit of their rights.

Nutrition, adequate housing, and health programs are basic to health, particularly for all Indian elderly deserving to live out their life with dignity.[1-2]

LEGAL ASSISTANCE

The primary reason for legal assistance is the cultural differences and the dual set of laws. The assistance should cover legal advice on: land ownership, taxes and wills, guardianships, consumer protection, credit arrangements, discrimination, protective services, and social security entitlement. In addition, legal aid should be available in courts and jails. This assistance is to help the elderly Indian in dealing with unfamiliar laws and customs.

An educational program to familiarize the elderly Indian with legal issues and their rights would be valuable. The program should include:

—personal rights
—sources of lawyers and how to use them
—estate planning, wills, and probate
—property rights
—rights relating to trust land
—credit obligations and rights
—taxes
—consumer fraud
—repossessions.

It would also be valuable to have bi-lingual Indian legal aid staff, court interpreters and law enforcement personnel. This would help eliminate elderly Indian defendants in non-tribal courts routinely pleading guilty due to lack of funds for legal services and no one to help them.

PROTECTIVE SERVICES

Protective services can range from "looking in on an elderly person to see if they need help" to protecting them from violence. The scope of protective services needed depends upon the health of the person and the local environment. Protective service includes three types of interventions:

1. Social
2. Medical
3. Legal.

The aims are prevention, protection and rehabilitation.

A discussion of the aim of protective services are included since it is not a normal part of the social services offered to the Indian elderly.

The terms "abuse" and "neglect" are mostly associated with children and rarely thought of as being applicable to elderly persons. In fact, most States have laws pertaining to child abuse and neglect; and most city departments of social services have protective services units specially created to meet the needs of abused and neglected children. From the federal government to local municipality, child abuse and neglect are recognized to be severe problems affecting children from all strata of life and from all ethnic, minority or majority groups and to be problems that touch the lives of thousands of children each year. Therefore, it comes as somewhat of a shock to the general population to learn that abuse and neglect also know no age limits and that the most revered members of our society, the aging and elderly, may also be in need of protective services. Sadly, the problem is pervasive; and the elderly American Indian is not exempt from this problem.

There is a growing awareness and concern on the part of American Indian leaders of the abuse and neglect of the elderly Indian citizen. Many such leaders acknowledge that this problem needs to be addressed. Numerous examples of abusive and neglectful treatment of elderly Indians have been cited that clearly indicate that these problems can no longer be underrated or hidden entirely. Some examples are:

— elderly persons who are either forced to leave their homes or who choose to leave their homes in the middle of the night in order to protect themselves from injury that might be sustained as a result of either an alcoholic-related domestic quarrel and unintended acts committed under the influence of alcohol.

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[1] **Report on Indian Health: Task Force Six: Indian Health**, Final Report to the American Indian Policy Review Commission, U.S. Government Printing Office, Washington, 1976.

[2] Hearings before Select Committee on Nutrition and Human Needs of the U.S. Senate: **Nutrition and Elderly**, U.S. Government Printing Office, Washington, 1977.

—elderly persons who are given no choice in sharing their homes with younger members of the family who are uncaring and who exploit them by: using their support monies to maintain their own lives; leaving their children for extended periods of time expecting they will be cared for; selling the groceries to obtain money that can be used to purchase liquor, thus causing the elderly person to go hungry; driving off with their automobile, with no regard for the person to whom it belongs; and expecting them to be accepting of the younger person's problems of alcoholism, unemployment, emotional instability and possibly inclinations toward violence.

—elderly persons who repeatedly give up their support money to pay jail fines for younger family members thus depriving themselves means for obtaining adequate housing, food, medicine, transportation, etc.[1]

These examples can obviously not be generalized to all Indian reservations or communities and can certainly not be attributed to the life of every elderly Indian citizen. However, they do portray the real life situation that some Indian persons may confront and tolerate on a daily basis: they have no other choice. Even if protective services support were available, the seeking of those services on a **voluntary** basis may be culturally offensive.

The concerns expressed by Mr. Woodenleg and the emerging facts point to a real need for protective services for the elderly Indian in order to help assure that these aged persons may live their lives in harmony with the land and in security within their family unit. In order to be maximally effective, protective services will augment support services by professionals in allied areas, such as medicine, social work, and mental health and alcoholism programs.

It is well known that the Indian culture is one that preserves the family and extended family relationships, that reveres the elderly member of the family for his wisdom and life experience and this carries on its traditions, values and beliefs by maintaining a unity of purpose and a unity in family cohesiveness. Abuse and neglect of the elderly is contrary to the Indian culture and life style. If these unique beliefs and life styles are to be preserved in this day of rapid change, the Indian family as a whole must be able to avail themselves of any support services when needed.

RECREATION SERVICES

Recreation services have been discussed in several prior sections. The availability of community centers, chapter houses, community kitchens and other group centers allows the culture, and tradition of the elderly Indian to be continued.

Transportation services for shopping and special events are equally important for the general well being of an elderly individual.

CULTURE

In a culture where the elderly hold or did hold great honor, the situation is difficult. The following statement by Elsie Basque, Boston Indian Council summarizes what the position of the elderly should be:

> "We are put on the sidelines. Left on the bench. There was a time when this was not true. When age and experience was a vital and dynamic part of the Native culture. Traditionally, the elders were held in high regard. They were listened to, honored, and included in the on-going life of the Indian community. There was no shame in having lived a good and full life. On the contrary, the older Indian was considered wise and knowledgeable. When problems arose, it was our answers, our advice and counsel, to which the people turned. We were the guides, the conscience, of the Indian nation. We were as much a part of tribal life as anyone else. We had our place, our home, among the family of Native people."[3]

The Indian is part of a culture where the family is most important. The relationships of family and community members are most important. When an elderly Indian has money, he would prefer to spend it on his grandchildren than invest in material items or buy food which is better for him. This is in conflict with the Anglo culture in which an individual tries to protect his money. The ceremonies and custom are the basis of life along with the concept of being in harmony with the spirit and land.

INFORMATION AND REFERRAL SERVICES

An information and referral service is an ideal addition to any set of comprehensive programs for the elderly. It provides the means for matching an individual's needs with available resources.

The normal functions of an information and referral agency are the following:[2]

> *"Information.* Collect information about all health and welfare resources in the community which may be brought into play in the interest of

[1] This section is written with the substantial contribution of Mr. John Woodenleg of the Northern Cheyenne Tribe.

[2] Lester, EE, Smith, EB, Depaoli, DM, and Graber, JB. 1968. Information and referral services for the chronically ill and aged. Public Health Reports, Vol. 83, No. 4.

[3] **The Indian Elder: A Forgotten American,** National Tribal Chairmen's Association 1978.

persons with health and related social problems. Maintain a central file of current information so that it is readily available for use by physicians, nurses, social workers, dentists, and other professionals, as well as by agencies, institutions, and organizations in the provision of services and in the extension and coordination of health and welfare services. Disseminate the information of appropriate health and social agencies, institutions, and other health-related groups for their use in planning and developing services to provide for unmet needs of the chronically ill and aged.

Referral. Make referrals to appropriate agencies or professionals for specific problems, such as medical care and financial assistance not provided by the IHS or accept referrals from professionals and agencies and from individuals and their families for counseling and consultation by the IHS staff.

Counseling. Provide individual counseling to help families and individuals solve their problems, which includes locating and matching their needs to the best community resources available.

Consultation. Provide professional consultation to physicians, nurses, dentists, physical therapists, social workers, and others providing direct services to the chronically ill and aged and to local communities, groups, and individuals concerned about gaps in services for the chronically ill and aged to assist in the development of new services and in the extension or change of existing services to more nearly meet the needs.

Coordination. Provide a coordinating mechanism for groups and agencies at the local, county, and State levels providing services to the same clientele or having common problems in the provision of services. Develop guidelines or tools which can be used by official planning groups and others responsible for developing policy and establishing programs to fill gaps or to strengthen community services and facilities.

Planning. Make data resulting from documented unmet needs available to communities for planning and have staff serve as members of community planning groups.

Training. Participate in both academic and inservice multidisciplinary training programs. Sponsor institutes designed to increase understanding of the needs of the chronically ill and aged for medical, paramedical, and welfare personnel. Provide orientation and training in the mechanics of planning, setting up, and implementing a program which may provide information, referral, counseling, and consultation.

Research. Build into the program a statistically sound research plan for purposes of program development and evaluation.

Interpretation. Provide publicity and continuous public relations efforts to reach health professionals, selected groups, and the general public through the use of public media, including newspapers, television and radio, meetings, newsletters, displays, and brochures."

The philosophy behind the information and referral service for the elderly Indian is that typical patterns of care (medical, hospital, and rehabilitation services) cannot solve the multiple problems. Consideration must be given to social, legal, economic, cultural, and living conditions as well. This ability to match the individual's need with resources can assist professional persons in arranging appropriate plans for continuity of care. Information provided by information and referral centers is also valuable for health planners. Health planners require resource availability information in designing health programs.

Local communication and transportation systems need to be taken into consideration when an IRS is planned. Also, unless the referrals are appropriate and solve an individual's problem, the individual, in most situations, will not try to find the needed resources or attempt to use the IRS again. This means there must be a trained staff, consisting of a social worker and secretary at a minimum.

The broad objectives for an information and referral service include:

a) developing an information, referral, and consultation service.[1]
b) identifying and eliminating gaps in community services for the chronically ill and aged.
c) developing a coordinating function to strengthen continuity of services for the chronically ill and aged.
d) influencing community planning toward better services for the chronically ill and aged.

Again, these objectives are influenced by the local environment; and the emphasis of the service will depend upon local needs and resources.

TRIBAL GOVERNMENT

The tribal government and its degree of self-determination is an important element of the physical environment. The tribal government is the one central agency which can be responsible for providing all services. Only the leaders' and the elderly members' involvement will bring governmental organizations

[1]Lester, EE, Smith, ED, Depaoli, DM, and Graber, JB. 1968. Information and referral services for the chronically ill and aged. Public Health Reports, Vol. 83, No. 4.

closer to satisfying their needs.[1] Since many of the elderly were involved in setting up their tribal governments, they also have more faith in them.

The elderly Indians are culturally tied to their tribal government. The methods and ways of the government are part of their way of life. Many of the elderly do not recognize other government organizations such as county and state. In return, the tribal government should provide resources for various programs for the elderly. These programs could include outreach, home health care, nursing homes and foster care.

As intertribal organizations become more active, collective efforts are possible. This will enhance the resources for developing demonstration projects as well as additional facilities and expanded service programs required.

INCOME

Income is not the only measure of ability to obtain resources; however, it is a good indication, especially where the individual has choice. It is true that surpluses and many resources are available at no cost; however, money is still needed for many items: food; clothes; utilities; home repair; and maintenance, including winterization and weatherization; and transportation.

Table 7 gives a clearer picture of income available to the elderly Indian (65 years and older). The mean income in 1970 was $2,336 and $1,657 for males and females, respectively, as compared to $4,550 and $2,214 for the general population.[2] This leaves little for necessities mentioned above.

Unemployment of the young Indian has a direct effect on family stability and the extended family support possible to the elderly. The past and present unemployment rate on reservations is far above U.S. levels; and they far exceed in some cases, the unemployment rates in the Great Depression, which reached 25 percent in 1933.[3-4] Table 8 indicates unemployment rates for selected States.

TABLE 7

Income Characteristics by Sex of the Indian Population 45-64 and 65 years and over in Urban and Rural Residences—1969

	45-64 years		*65 years and over*	
	Male	*Female*	*Male*	*Female*
Total population	49,822	54,929	20,702	23,100
Without income	3,436	19,408	1,221	3,565
With income	46,386	35,521	19,481	19,535
$1 to 999	6,243	11,206	5,208	8,653
$1000 to 1999	6,059	7,961	6,930	6,896
$2000 to 2999	4,863	4,413	3,264	1,983
$3000 to 3999	4,576	3,892	1,456	627
$4000 to 4999	3,926	2,527	835	436
$5000 to 5999	3,782	1,843	488	227
$6000 to 6999	3,782	1,402	263	160
$7000 to 7999	3,113	1,060	303	136
$8000 to 8999	2,573	521	177	98
$9000 to 9999	1,702	251	126	87
$10,000 to 14,999	4,340	700	282	116
$15,000 or more	1,427	145	149	116
Median income[3]	$4,370	$1,867	$1,654	$1,162
Mean income[3]	$5,217	$2,718	$2,336	$1,657

Source: 1970—Census of Population—U.S. Department of Commerce—United States of America—Final Report PG(2) 1F - American Indians - Table 6, page 61.

[3]Median and mean income includes persons without income.

TABLE 8

Percentage Indian Labor Force Unemployment in Selected States*

State	*1967*	*1969*	*1971*
Arizona	37	50	41
Colorado	72	68	45
Michigan	31	48	62
Nevada	25	29	46
New Mexico	42	49	36
North Dakota	50	58	60
Washington	21	26	35
Wyoming	25	27	45

* Compiled from Indian Reservation Labor Force and Unemployment Annual Report of BIA (unpublished). Provided Task Force April 1978.

[1]Paulo Freire, **Pedagogy of the Oppressed**, New York, The Seabury Press, 1973.

[2]The mean income is where half the group are above and half are below the figure.

[3]U.S. Congress, House of Representatives, Committee on Interior and Insular Affairs, Indian Unemployment Survey, 88th Congress, 1st session, Washington, D.C.: U.S. Government Printing Office, 1963.

[4]The American Indians, Answers to 101 Questions. U.S. Dept. of Interior, Bureau of Indian Affairs, June 1974, p. 18.

The unemployment rates for the elderly are not so important since they relate only to people seeking employment. The percent of elderly in the civilian labor force or those earning an income is the important fact (Table 9). Only 17.2% and 8.5% of the males and females, respectively, over 65 years are even in the labor market (1970 census data).

These data mean that many elderly Indians do not have sufficient income to cover the cost of those necessities mentioned before. In those cases where the elderly person lives with his extended family or in a tribal facility for the elderly, the problem is less severe. For the remainder of the elderly, the need for additional resources is critical.

TABLE 9

Percent Indians in Civilian Labor Force for 45 to 64 years and 65 years and over

	45 to 64 years	*65 years and over*
Males		
Total	49,822	20,702
Labor force	35,538	3,564
Percent in labor force	69.3%	17.2%
Females		
Total	54,929	23,100
Labor force	20,269	1,955
Percent in labor force	36.9%	8.5%

Source: U.S. Department of Commerce, Social and Economic Statistics Administration, Bureau of Census, Subject Report: American Indian PC(2) - 1F 1 Table 6, June, 1973.

CLIMATE

The climate and weather conditions play a role in both the individual's health and ability to seek service. These relate to the type of housing needed and also affects availability of transportation.

The importance of the climate and the role temperature plays in the aging process is validated in many studies.[1-3] The conclusion is the rate of energy consumption is related to loss of energy to the surrounding physical environment, meaning that extremes of heat lead to high metabolism and shorter life. Bourlier thinks that:

> "...temperature, both environmental for cold-blooded species and central for warm-blooded animals, has something to do with the rate of aging process."[4]

If this is correct, key elements in prolonging the life span of the elderly Indian are adequate winterization, with heating and cooling systems in the houses. Clothes must also be suited to the temperature. Older people are more comfortable at higher temperatures. This is due to circulatory impairments. For these reasons, climate needs to be considered by planners and architects who design housing for the elderly Indian.

Transportation is also affected. As transportation becomes limited because of snow and mud, the ability to obtain or receive food and other services is limited. More than likely, areas with poor transportation systems will be lacking, also, in communications systems and other electrical conveniences, including lighting and refrigeration.

CLEARING HOUSE

A great deal has been written about the problems of long-term care facilities, the lack of comprehensive services, the badly needed housing for the elderly, and the expanded welfare needs. Many programs have dealt with the problems of the elderly. However, information about these is difficult to find or fragmented.

What is needed is a central repository for storing, retrieving and disseminating information on all the different programs concerning elderly Indians. Reports on evaluation of programs could be included and be made available to persons wishing to start similar programs.

Information could be printed, or placed on audio-cassettes, or audio-visual cassettes, for example. The main objective would be to facilitate information exchange on what works and what does not work in the Indian community.

SUMMARY

The physical environment of the elderly Indian was discussed in this background paper. It emphasized those problems that surround an individual and services required to eliminate the problems. The main theme was to maintain an elderly person's independence and provide him with choices. Where choices exist, a person is more likely to receive services needed.

[1]F. Bourliere, "The Comparative Biology of Aging," Journal of Gerontology, Supplement 2, 13:16-24, 1958.

[2]Maxcy and Rosenau, Preventive Medicine and Public Health, Tenth Ed, Appleton, Century, and Crofts, New York, 1973, Chapter 22.

[3]Medical Clinic of North America. Vol. 60, No. 6, November 1976, ppl 1289-1296.

[4]Ibid., p. 19 (environmental refers to surroundings temperature and central refers to body temperature).

The physical environment was seen as all physical, social and economic constraints that face the elderly Indian. Included were factors such as land, income, housing, sanitation, landscape, transportation, referral service, recreation, nutrition, climate, air and water resources, culture, tribal government, legal issues, protection, and community relations. Services that could potentially eliminate these constraints were discussed.

This paper attempts to address the environment of the elderly Indian in terms of his individual and community surroundings. It emphasizes the need for examining each component of the environment in terms of providing an individual with options most compatible with his or her life style. It also calls attention to some of the constraints related to sources of support for obtaining the desired environment. Among the more important aspects of the environment discussed are the range of living arrangements; income; and means of communication, including rural electrification and transportation.

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APPENDIX E

Data and Materials to Support a Community Education and Safety Program to Reduce Accidents Among Elderly Indians

INTRODUCTION

In order to determine and define the accident problem among the elderly within the Indian community, statistical information had to be assembled. For this purpose accident data print-outs provided by Indian Health Service were reviewed, analyzed and interpreted.

Except where noted, the data studied encompassed 10 Indian Health Service Areas; namely, Navajo, Aberdeen, Phoenix, Alaska, Oklahoma, Billings, Albuquerque, Bemidji, Portland, and Tucson. Further, the statistical data were broken down by age groups: 45 to 54, 55 to 59, and 60 and over.

Comparative data were obtained from the National Safety Council, "Accident Facts," 1977 edition.

Safety materials relative to the elderly from the National Safety Council were reviewed, also from the U.S. Consumer Product Safety Commission and National Fire Protection Association. Inquiries were made as to additional governmental agencies and safety organizations providing needed assistance for the development or continuation of a safety program for the Indian elderly.

These organizations and agencies have provided input into a number of safety publications related to the elderly and aging. Due to the pre-existing work, it is felt that "re-inventing the wheel" is unnecessary in developing extensive safety materials and publications related to safety for the Indian elderly. Recommended instead is a selected number of existing materials which will suffice in promoting the inauguration of safety programs for the elderly.

The overall goal is to insure that the elderly American Indian receives the necessary attention for protecting himself or herself from avoidable accidents.

The Education phase will be directed at three target audiences: 1) the elderly and those who have elderly individuals living with them, 2) those who professionally provide services for the elderly and aging (nursing homes, CHR's, recreational staff and all support personnel dealing with aging or elderly clients), and 3) home owners, apartment tenants, mobile home users, and the handicapped.

The Engineering phase will have emphasis on addressing Housing Authorities, nursing home staff, Tribal Councils and others responsible for housing the elderly to encourage them to provide design features that enhance the safety of dwellings for the elderly.

Many organizations are nationally involved with problems related to the aging or aged individual. Among those involved are:

1) National Safety Council*
2) National Council on the Aging
3) National Council of Senior Citizens
4) American Health Care Association (formerly American Nursing Home Association)
5) American Association of Retired Persons
6) American Red Cross
7) National Fire Protection Association

Government Agencies:
Administration on Aging
Consumer Product Safety Commission

FINDINGS

To meet the objectives of this project, it was necessary to analyze relevant data and present same in graphic form for simplicity in understanding. Further, it was necessary to search for public information and education materials relating to the elderly. The data reflect Areas** having major need for programs, namely, Oklahoma, Navajo, Aberdeen, Billings, and Phoenix. This is determined not only by the volume of accidents but by the high accident rate per 100,000 population. Motor vehicle accidents should receive greatest attention in the Navajo, Aberdeen, and Alaska Areas. They are closely followed by Oklahoma, Phoenix and Albuquerque Areas. In the environmental factor category, the target priority changes to Navajo, Phoenix, and Albuquerque Areas, closely followed by Oklahoma, Aberdeen, and Alaska. It is interesting to see Oklahoma leading in the per 100,000 population category, followed closely by Navajo and Aberdeen. In overall causes of accidents to the elderly, "falls" leads the list by a large margin, as seen on Graph K, followed by "cutting and piercing," "motor vehicle," "environmental factors," and "animal related," in that order. Insofar as place of injury is concerned, the data indicate that "outside the home" leads with "inside home," "highway and street," "farm," "industrial place" and "recreation/sport" following in that order. It is encouraging to note that "public building" and "residence-institute" categories contain a small number of accidents.

The accident death rate for 60 years and over is

* See last page of report for addresses of sources cited.

** "Area(s)" refers to Indian Health Service Area Offices. California and United Southeastern Tribes Program Offices were not included unless noted as in graphs K, L, and M.

staggering, with 168.1 per 100,000 population for the Indian population, as compared to U.S. all races, 87.5 per 100,000 population. The "falls" category is the leading cause of accidents in the Indian community.

The leading fatality accident category is motor vehicles and shows a rate of 23.7 per 100,000 population for total United States and 56 per 100,000 population for the American Indian. The next category, "falls," is interesting as the total United States rate per 100,000 is 33.7 while the American Indian is 29.5 per 100,000. Burns show 17 per 100,000 population for total United States and 20.6 per 100,000 population for the American Indian.

The statistical data clearly reflect a need for educational safety programs which will focus on the elderly. A safety packet for working with and for the elderly can be effective if it contains the following information:

National Safety Council*

1. The Hazard Haunted House
2. Winter Snow Falls
3. All About Fire
4. Accidents to the Elderly
5. Pre-Retirement Tips
6. A Safer Home for Mom and Dad
7. Winter Walking
8. Home and Product Safety Facts
9. Watch Your Step (poster)
10. Street Crossing (poster)
11. Retirement Living
12. Older Americans' Accident Facts
13. Starting a Safety Program
14. Radio/Television Spots
15. Forget Things?
16. Poor Sight?
17. To Protect the Elderly from Falls (poster)
18. The Senior Citizen in Traffic
19. An inexpensive leaflet (Don't Fall for an Accident)

National Fire Protection Association

1. Fire Safety for You
2. Flip chart on Fire Safety (Indian)
3. Fire Safety poster "Protect Your Heritage" (Indian)

U.S. Consumer Product Safety Commission

1. Flammable Fabrics and the Elderly

The engineering needs for a safer home are also an area which will contribute tremendously to safety for the elderly. The information contained in Guideline 1, "A Design Guide for Home Safety," U.S. Department of Housing and Urban Development, should be followed. Other references include:

National Safety Council

Housing for the Elderly

2. Accidents among the Aged

National Fire Protection Association

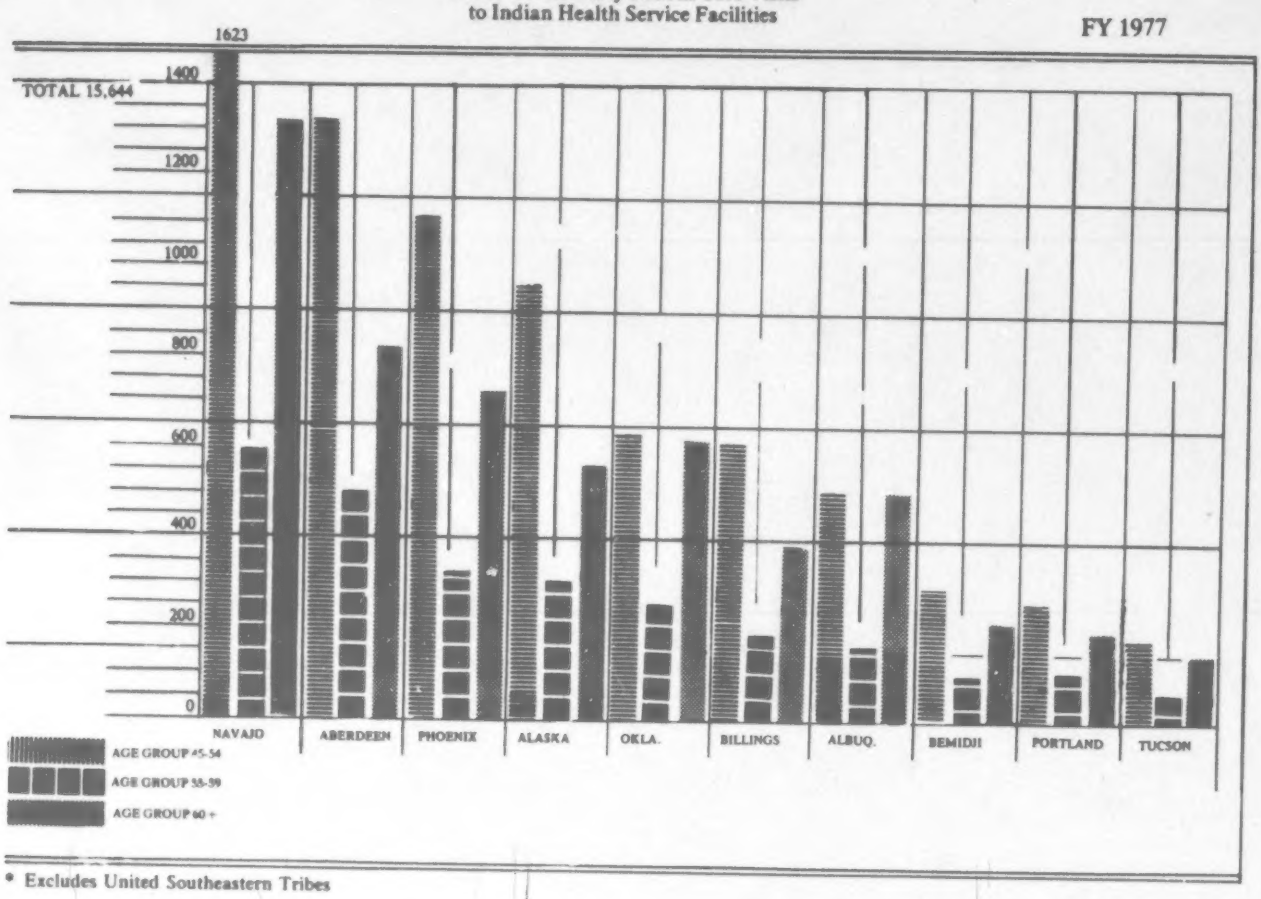
1. Safety Codes for the Elderly

* See last page of report for addresses of sources listed.

GRAPH A
Comparative Accident Incidence by Age Group

Total* Ambulatory Patient Care Visits to Indian Health Service Facilities

FY 1977



* Excludes United Southeastern Tribes

This graph contains total accident incidences for ages 45 and over and is broken up into three groups: ages 45 to 54, ages 55 to 59, and age group 60 and over. Total accidents for all age groups contained herein is 15,644. The total of all accidents of ages 60 and over was 5,570. This represents 35.6% of the total accidents occurring among persons over 45 years of age.

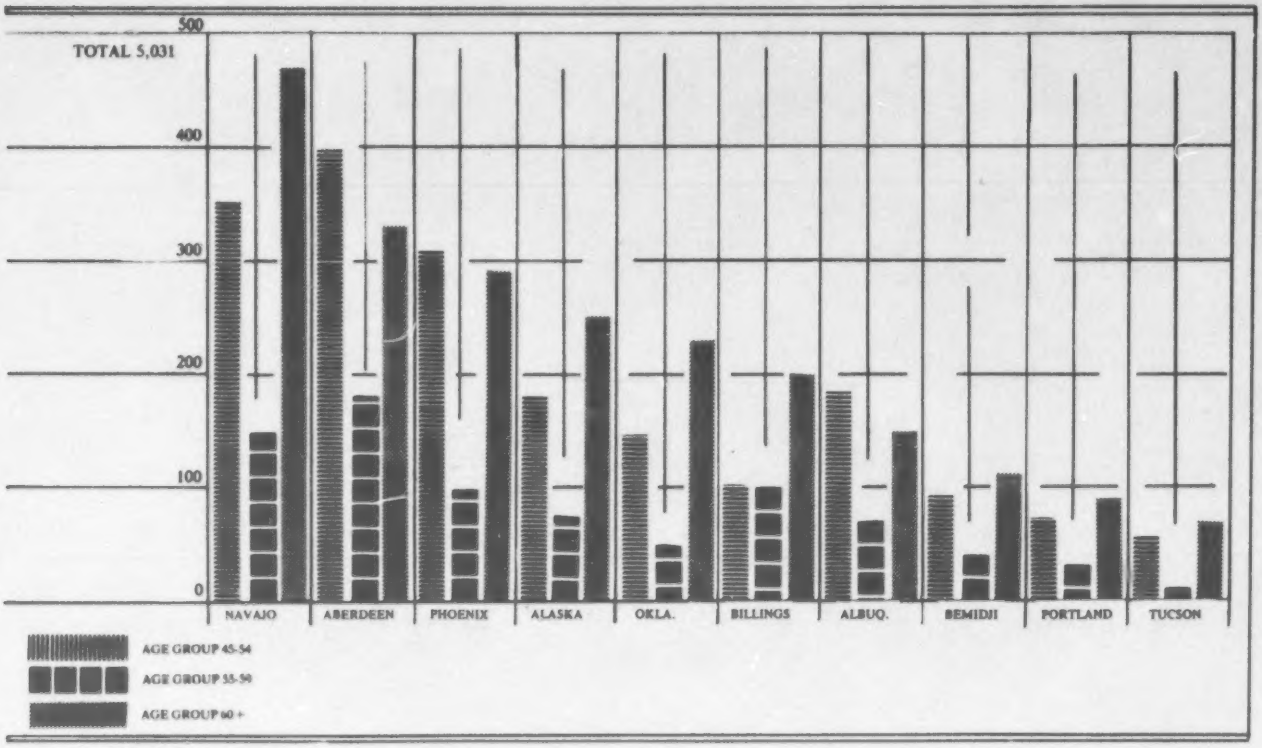
Further analysis reflects that three Areas; namely, Navajo, Aberdeen and Phoenix, should be target areas because of the large volume of accidents affecting the 60 and over age group. Of the total 5,570 accidents in the 60 and over age bracket, 2,892 of these accidents were in the Navajo, Aberdeen and Phoenix Areas. These three Indian Health Service Areas comprise 51.9% of all the accident incidences in the 60 and over age group.

GRAPH B

Accidental Falls

Total* Ambulatory Patient Care Visits to Indian Health Service Facilities

FY 1977



* Excludes United Southeastern Tribes

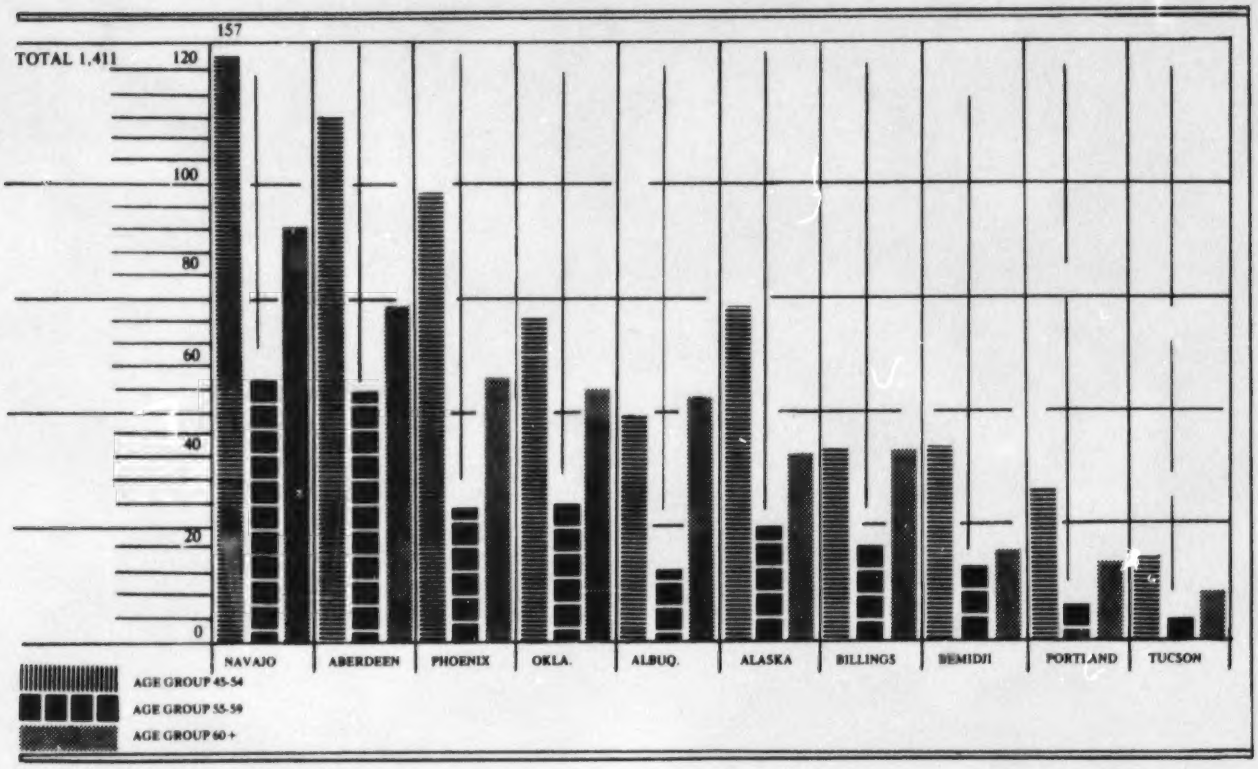
This graph provides an illustration of the category Accidental Falls, which is by far the leading contributor of accidents to the Indian community. The age group of 60 and over is widely exposed to this category, and it certainly is an area of concern. Of a total 5,031 accidents, 2,178 or 43.3%, occurred to the 60 and over age group. The same three areas are leading in numbers; 49.8%, occurred within these areas.

GRAPH C

Cutting and Piercing Accidents

Total* Ambulatory Patient Care Visits
to Indian Health Service Facilities

FY 1977



* Excludes United Southeastern Tribes

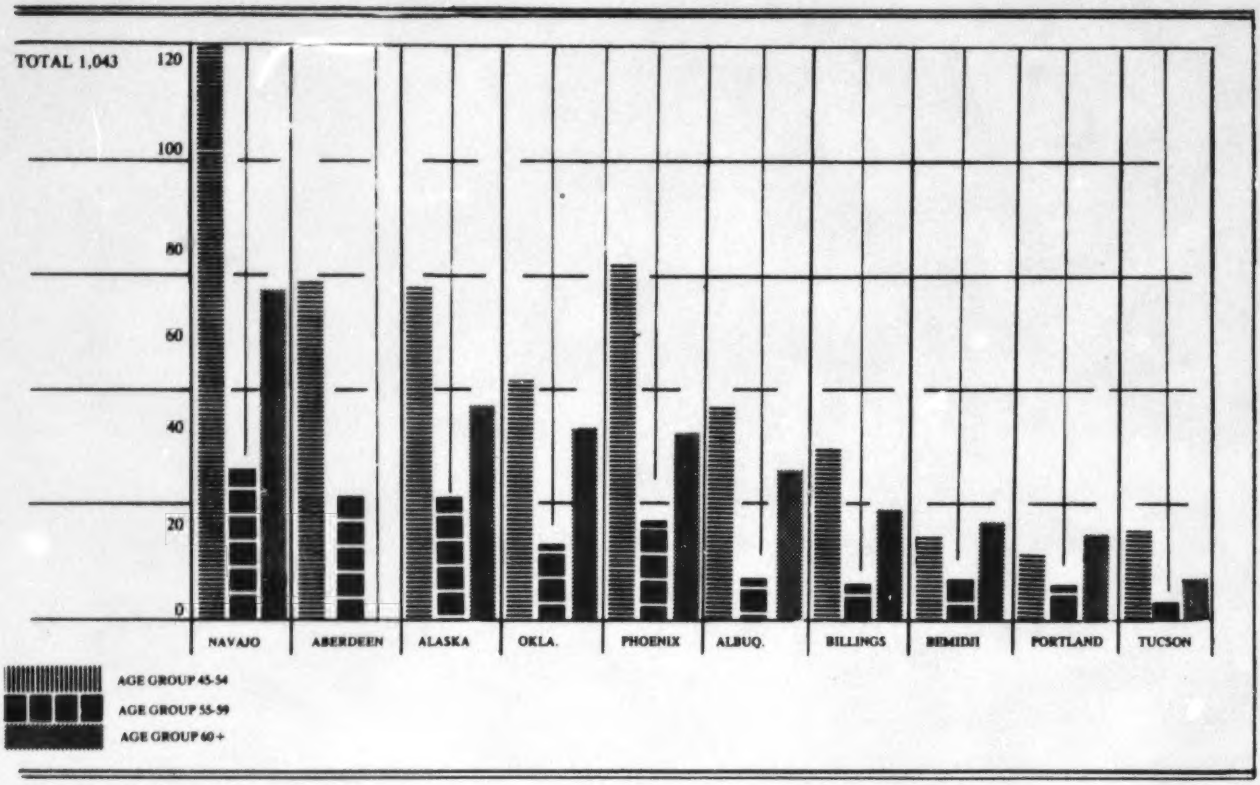
This is another area of concern, with a total of 1,411 accidents, of which 460 occurred to the 60 and over age group, representing 32.6%. Again, the leading Areas in the number of accidents are Navajo, Aberdeen and Phoenix. This is consistent as they represent 222 of the 460 accidents, or 48.3% occurring within the 60 and over age group.

GRAPH D

Motor Vehicle Accidents

Total* Ambulatory Patient Care Visits
to Indian Health Service Facilities

FY 1977



* Excludes United Southeastern Tribes

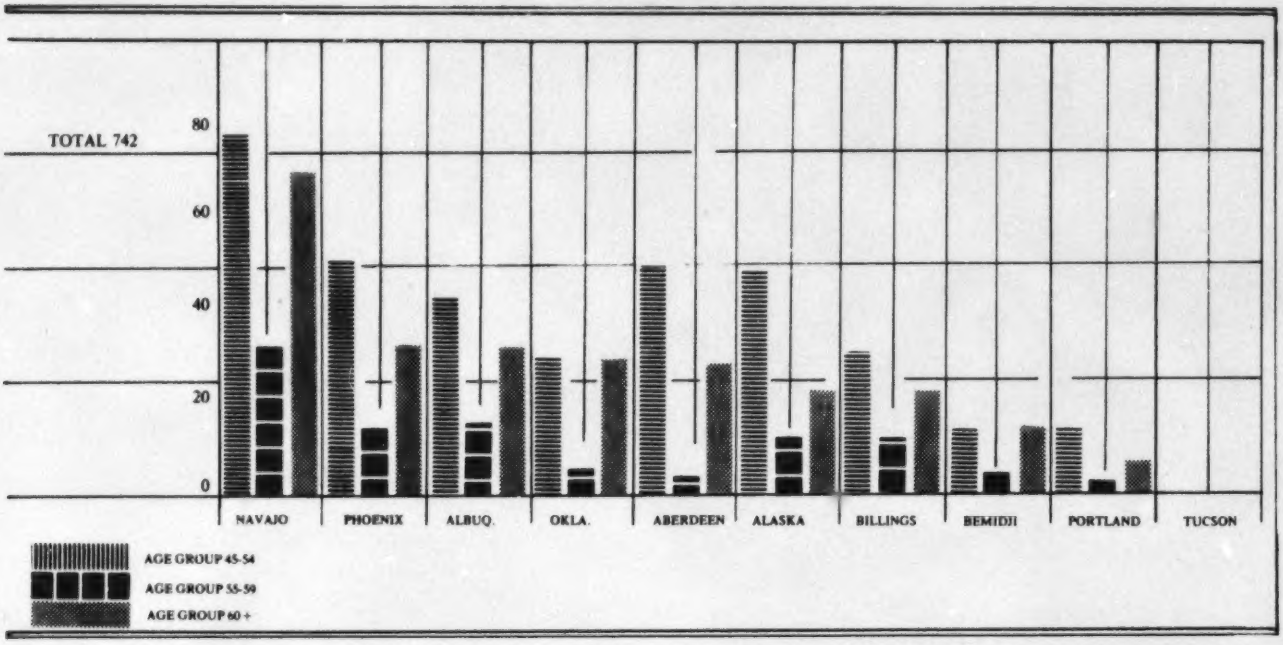
This graph clearly illustrates that the leading age bracket contributing to motor vehicle accidents is the 45 to 54 age group. However, the second contributor appears to be the age group of 60 and over. Out of 1,043 accidents, 348, or 33.2%, occurred within the 60 and over age group. The three leading Areas in numbers are somewhat changing as Phoenix has dropped down to fourth and is replaced in the third category by Alaska and Oklahoma. The total motor vehicle accidents within the four leading Areas; namely, Navajo, Aberdeen, Alaska, and Oklahoma, is 204 and represents 58.6% of the overall motor vehicle accidents occurring within the 60 and over age group.

GRAPH E

Environmental Factors

Total* Ambulatory Patient Care Visits
to Indian Health Service Facilities

FY 1977



* Excludes United Southeastern Tribes

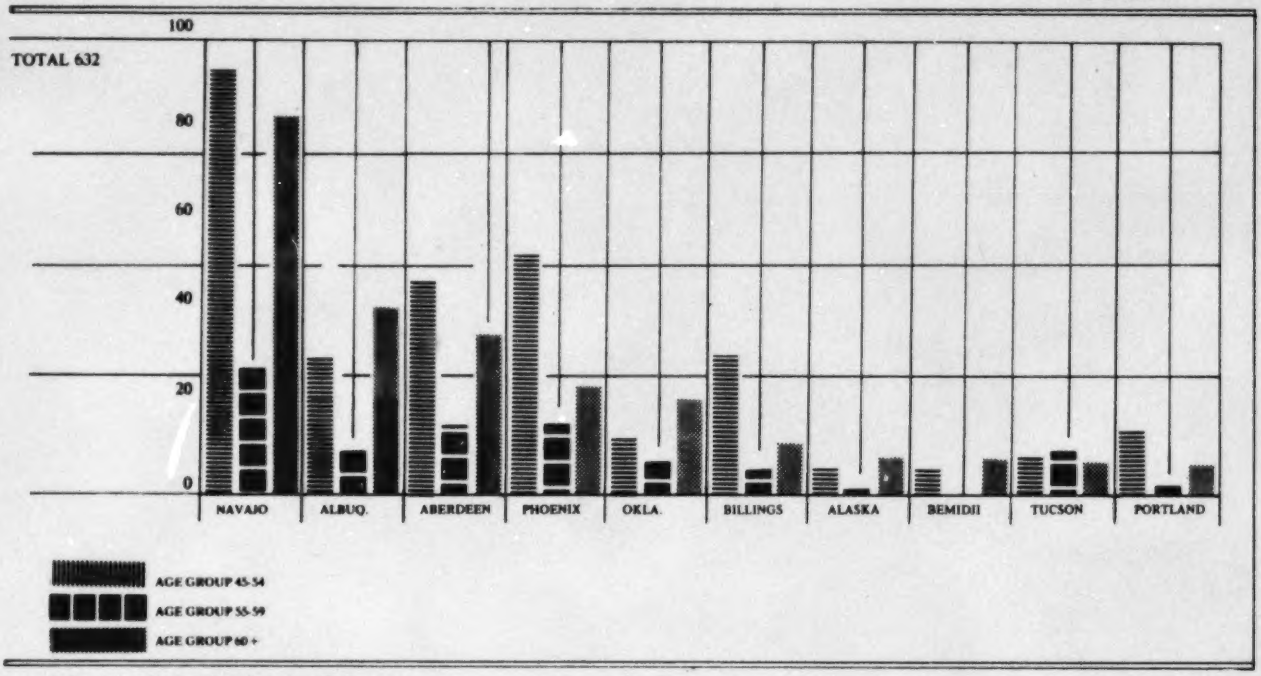
This graph illustrates the environmental factor accident problem in which the age group of 45 to 54 is the leader, with the 60 and over age group running second. The four top areas in volume have changed somewhat and now comprise Navajo, Phoenix, Albuquerque, and Oklahoma. Out of the 742 accidents, the 60 and over age group represents 264, or 35.6%. The four leading Indian Health Service Areas, Navajo, Phoenix, Albuquerque, and Oklahoma comprise 168 accidents, or 63.6% of the overall total. In trying to determine necessary programs and the designation of target areas, "environmental factors" should be better defined. Without definite definitions of this data, no reasonable attempt at program development can be made. Definitions are necessary for identification and to produce and establish a problem profile.

GRAPH F

Animal Related/Bites

Total* Ambulatory Patient Care Visits
to Indian Health Service Facilities

FY 1977



* Excludes United Southeastern Tribes

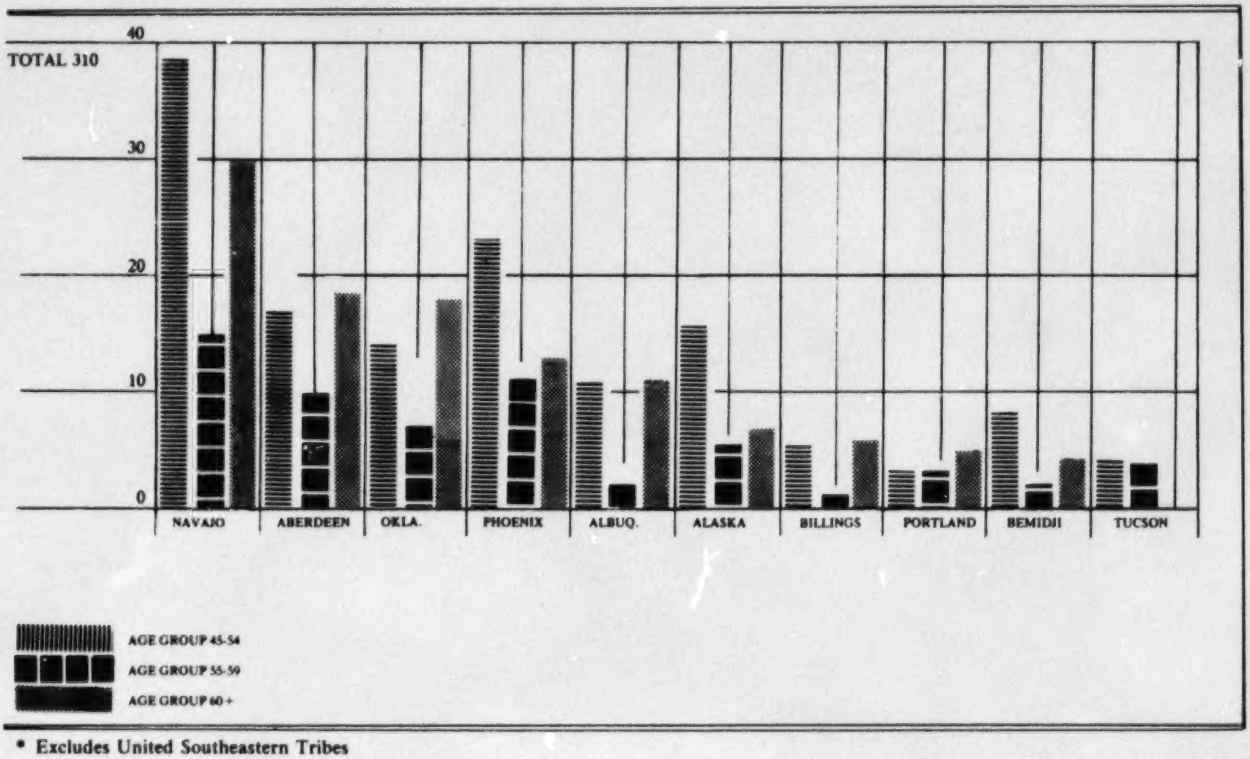
This information readily illustrates to the extent that the age group of 60 and over are affected by animal-related bites/accidents. The total reflected here is 632 accidents in this category, of which 243, or 39.9%, occurred to the 60 and over ages. Again, three Areas stand out in the number of accidents in this category, and the second and third positions change, making it Navajo, Albuquerque and Aberdeen. The total in these three areas constitutes 157 accidents, or 64.6% of the overall total. The remaining Indian Health Service Areas appear to have a minimal number of accidents in this category. These bites are inflicted largely by warm-blooded animals.

GRAPH G

Accidental Burns

Total* Ambulatory Patient Care Visits
to Indian Health Service Facilities

FY 1977



* Excludes United Southeastern Tribes

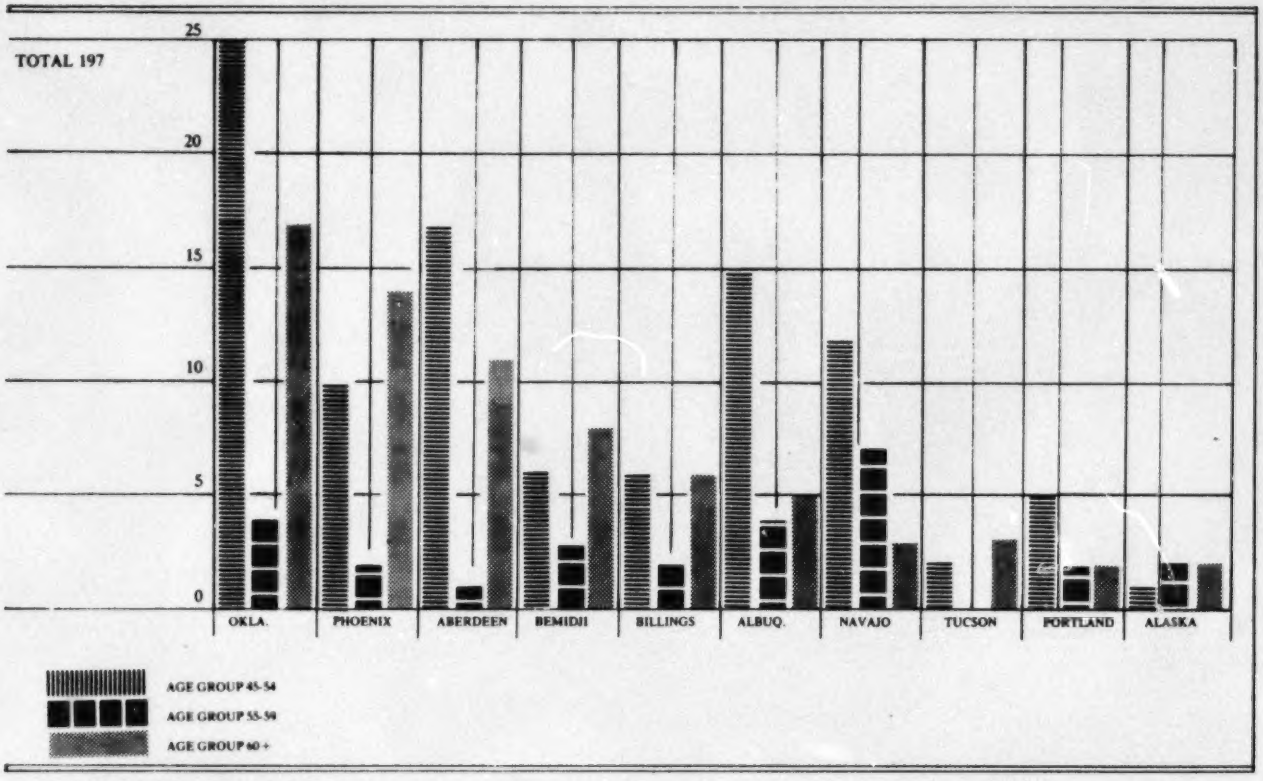
This graph illustrates the number of accidental burns; and even though the numbers are small, this is an area of concern as, again, definition, the type of fire, and the degree of damage should be pertinent information relating to this accidental category. With the influx of new housing and new businesses on Indian reservations and communities, this is an area of concern, particularly as it relates to the elderly age group of 60 and over. The age area of concern here is the group 45 to 54, as it exceeds the other age groups being studied, which are 55 to 59 and 60 and over. It is pointed out that the volume of accidental burns in the areas of ages 45 to 54 and the second area in number, age 60 and over, exceed the 55 to 59 age group. Out of 310 burn accidents, 112 were in the 60 and over age bracket, representing 36.1%. The three leading Indian Health Service Areas which constitute the majority of accidental burn accidents, which include Navajo; Aberdeen and Oklahoma, reflect 67 accidents, or 59.8% of the overall total.

GRAPH H

Stings and Venoms

Total* Ambulatory Patient Care Visits to Indian Health Service Facilities

FY 1977



* Excludes United Southeastern Tribes

This graph demonstrates the numbers affected by stings and venoms, and again there are three leading areas. Out of a total of 197 accidents, the 60 and over category represents 71, or 35.6%. The three leading areas of Oklahoma, Phoenix and Aberdeen represent 42 accidents, or 59.2% of the overall total for the 60 and over age group. It would be helpful to define the types of stings or venoms illustrated by these accidents. Only by so doing could target areas be selected and solutions be forthcoming.

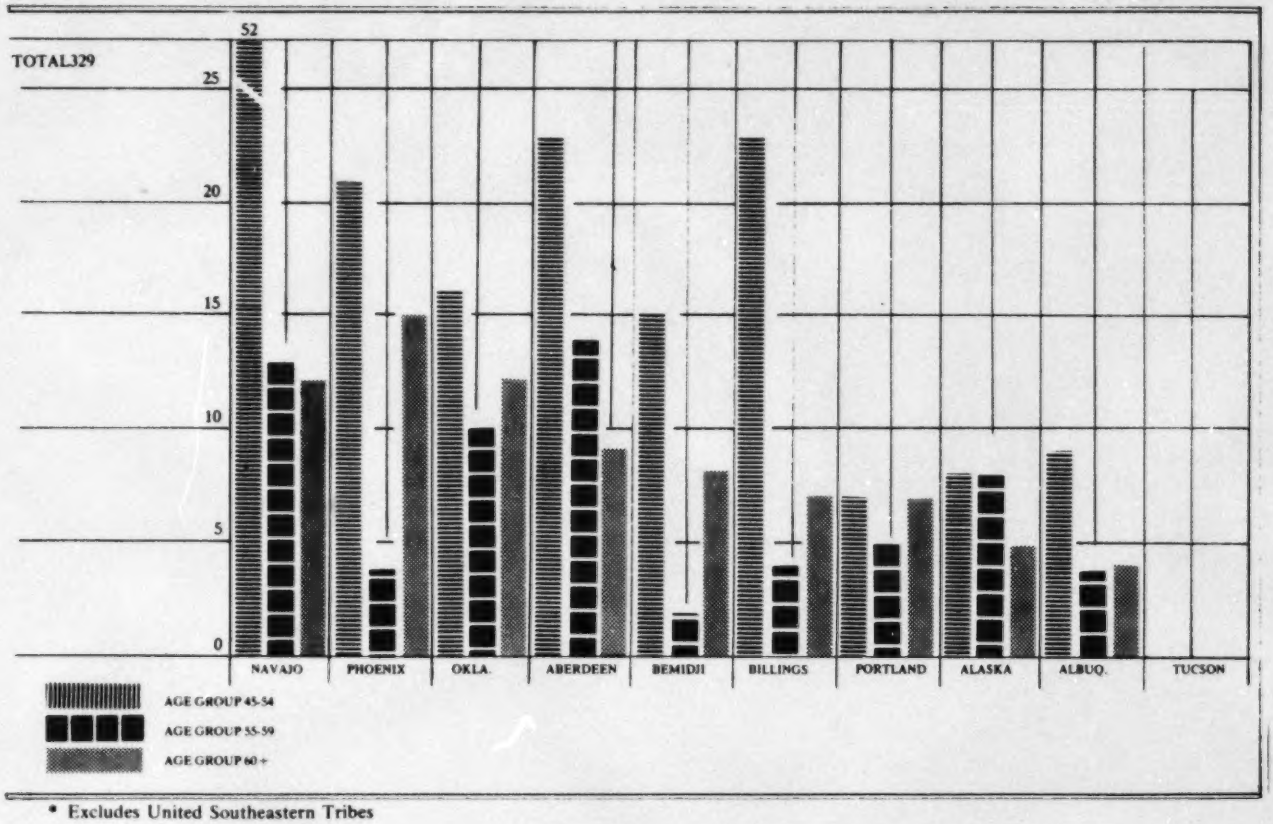
198

GRAPH I

Machinery Accidents

Total* Ambulatory Patient Care Visits to Indian Health Service Facilities

FY 1977



* Excludes United Southeastern Tribes

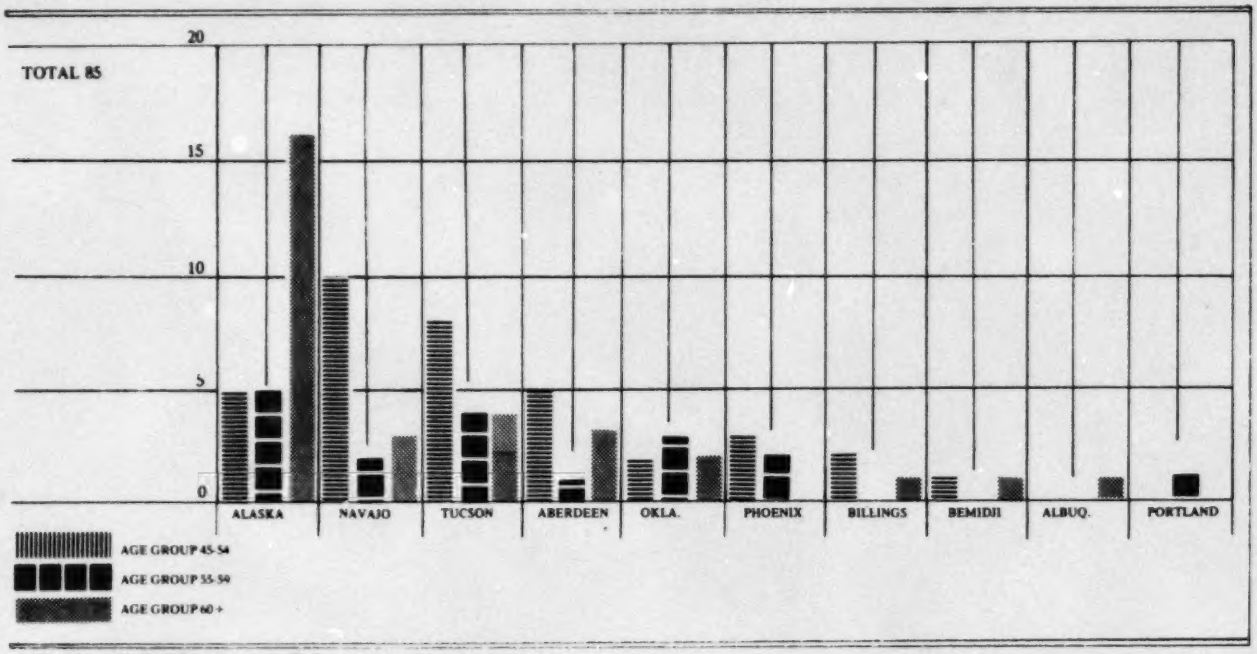
This particular graph reflects total machinery accidents. Age group 45 to 54 is by far the largest segment affected by these accidents. However, age groups 55 to 59 and 60 and over are affected substantially. Out of a total of 329 accidents, 60 and over involve 79 persons, or 24.0% of the total. Four areas which constitute a majority of accidents are Phoenix, Navajo, Oklahoma, and Aberdeen, with 60.8%.

GRAPH J

Accidental Poisoning

Total* Ambulatory Patient Care Visits to Indian Health Service Facilities

FY 1977



* Excludes United Southeastern Tribes

This category of accidents, while not particularly voluminous, is significant as affecting a certain number of the population, particularly the Alaska Natives. Out of a total of 85, the number affecting the 60 and over age bracket is 31, or 36.5% of the overall total. The areas affected with the majority of accidents are Alaska, Tucson, Navajo, and Aberdeen, which comprise 83.9% of the overall total. Out of the 26 accidents occurring in the above-mentioned areas, 16 occurred to Alaska Natives, which is an alarming rate for the overall number of accidents.

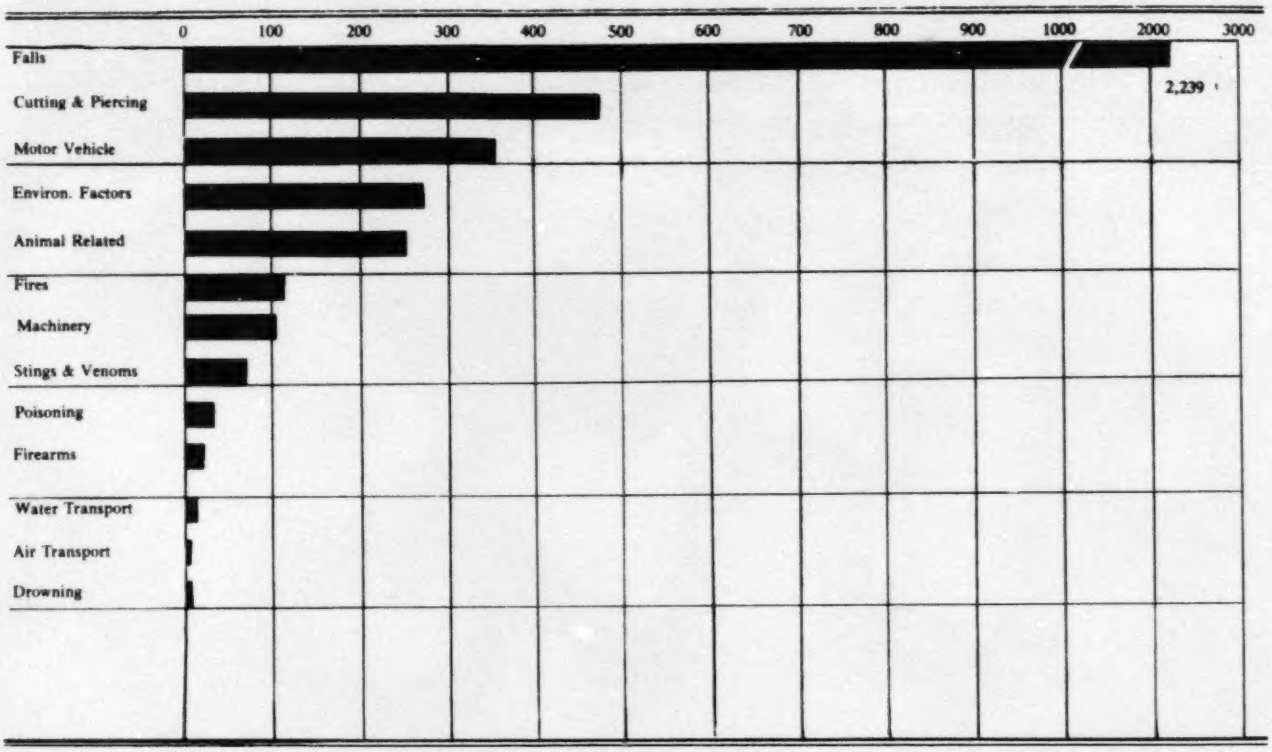
200

GRAPH K

External Cause of Injury

FY 1977

Total* Ambulatory Patient Care Visits
to Indian Health Service Facilities



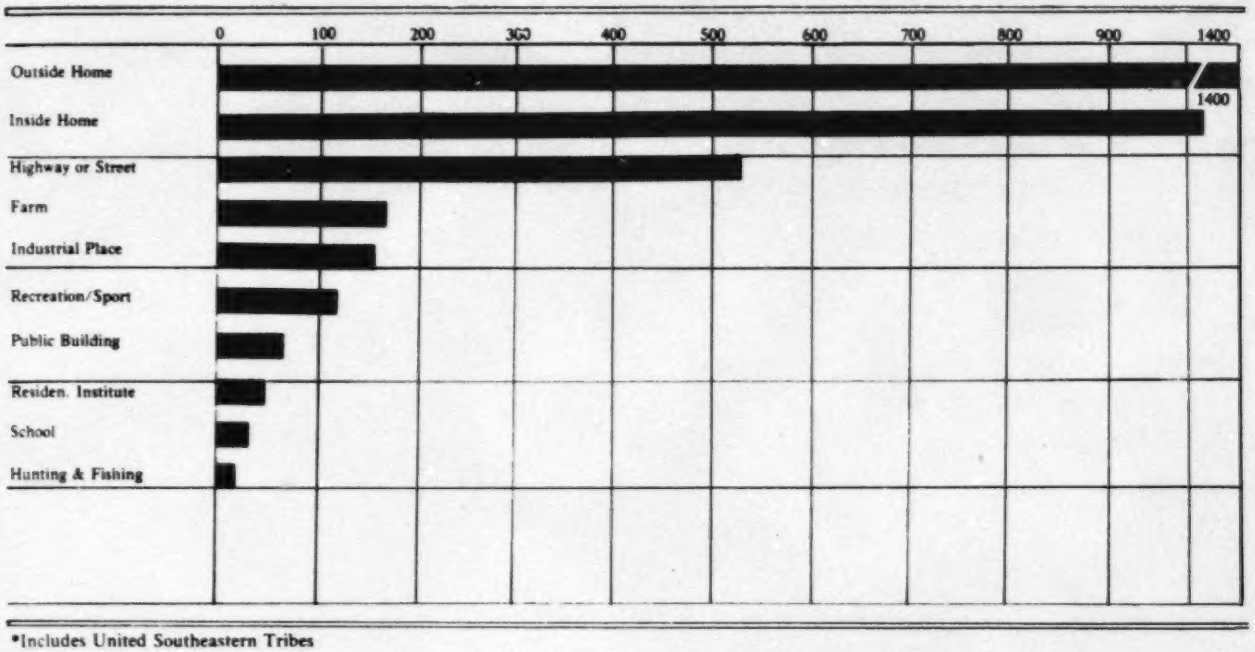
*Includes United Southeastern Tribes

This graph reflects the total external cause of injuries of age group 60 and over by category certainly takes its toll among the age 60 and over group, as out of a total of 5,732 accidents, falls were responsible for 2,239, or 39.1% of the overall total. Following Falls, the accident categories in that order are Cutting and Piercing, 489 accidents, or 8.5%, Motor Vehicles, 356 accidents, or 6.2%; Environmental Factors, 274, or 4.8%; and Animal Related, 251, or 4.4%.

GRAPH L

Relating to Place of Injury

Total* Ambulatory Patient Care Visits to Indian Health Service Facilities



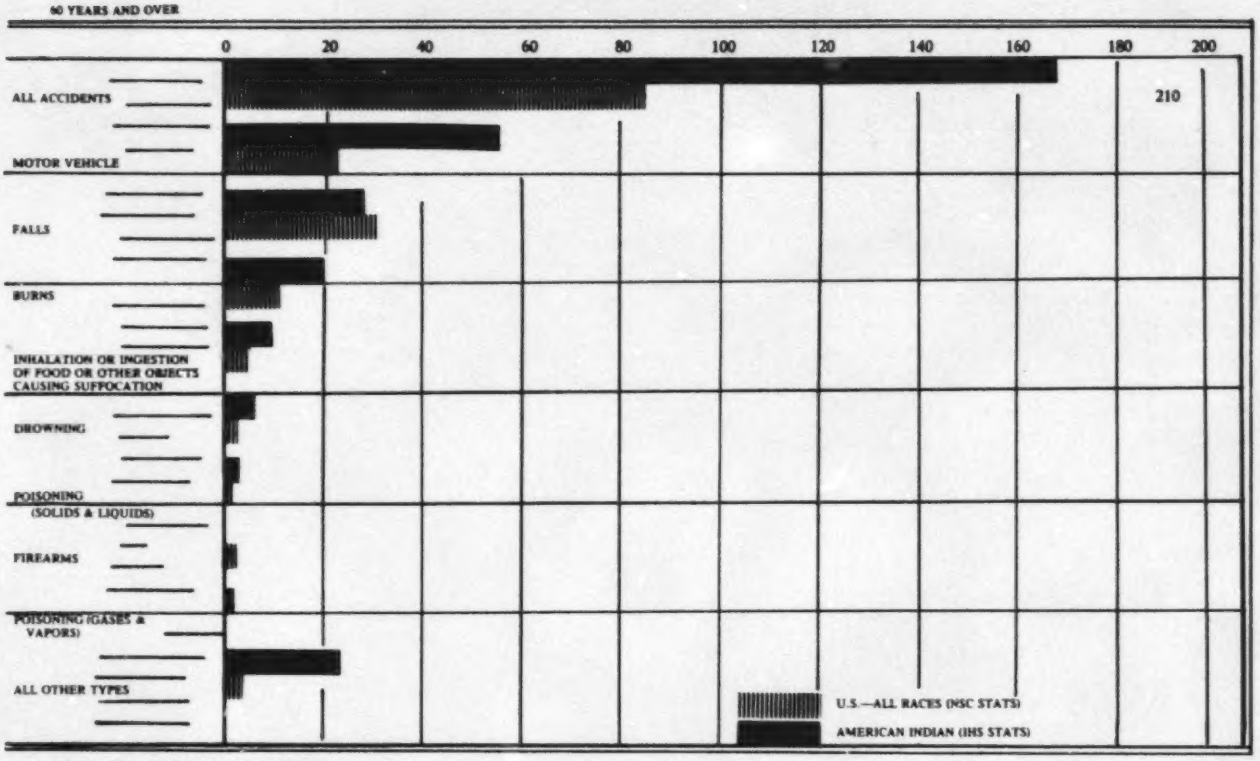
*Includes United Southeastern Tribes

This graph relates to place of injury, for age group 60 and over. It produces a general picture of where these accidents are occurring. For the 60 and over age group, out of a total of 5,732 accidents, 1,460, or 25.4%, occurred outside the home. A total of 1,308 accidents, or 22.8%, occurred inside the home. Relating to highway or street accidents, 539, or 9.4%, occurred to the 60 and over age group.

GRAPH M

Leading Causes of Accidental Deaths

1976 Death Rates (per 100,000 population) for Leading Accidents Causes
Indians in 25 Reservation States vs. U.S. All Races Age 60 and Over



* Includes United Southeastern Tribes

An attempt is made here to reflect leading causes of accidental death by using comparative data; that is, Indian Health Service vs. National Safety Council statistics. As used universally, the rate per hundred thousand population is a recognized yardstick to measure accidental data. These statistics reflect wholly the 60 and over age bracket. A comparison is shown of the American Indian population vs. United States—All Races, as reflected by the National Safety Council's statistics. With the U.S. figures of 60 and over age bracket, there are 32,000,000. Total deaths were 28,800, which sets a rate per 100,000 population at 87.5. With the national Indian population reflecting a total of 67,810 in the 60 and over age bracket, there were 114 deaths, which sets the rate per 100,000 population at 168, almost three times the U.S.—All Races rate.

CHART I

ACCIDENTS
FY 1977

Area	Out Patient Visits				Out Patient Visits Poisoning and Violence				Total Hospital Discharges Contract and IHS Facilities				Total Hospital Discharges Accident, Poisoning & Violence			
	All Ages	45-64	60+	65+	All Ages	45-64	60+	65+	All Ages	45-64	60+	65+	All Ages	45-64	60+	65+
Aberdeen	380,435	59,156	37,760	27,793	29,544	2,868	1,504	730	18,003	3,067	2,120	1,648	2,905	419	209	133
Bemidji	86,625	16,687	10,255	7,985	7,150	742	409	222	2,466	440	358	293	349	42	28	19
Alaska	310,316	47,317	25,203	17,073	22,516	2,502	1,119	530	12,356	1,979	1,353	1,030	1,985	293	144	93
Albuqu.	212,254	27,071	20,173	14,612	15,721	1,381	1,052	641	6,082	817	796	637	940	104	78	53
Billings	228,276	33,848	20,455	14,475	17,771	1,443	842	377	8,415	1,286	907	687	1,047	131	77	50
Navajo	629,568	72,587	49,333	32,838	47,471	4,176	2,858	1,615	19,983	2,019	2,108	1,585	2,758	322	214	142
Okla. City	452,740	90,065	67,129	55,267	16,437	1,621	1,054	623	12,947	2,289	2,001	1,663	1,244	181	122	88
Phoenix	393,617	55,647	33,906	23,593	31,096	3,011	1,676	861	15,750	2,394	2,049	1,637	2,783	403	273	200
Portland	156,765	23,610	14,799	10,692	10,157	731	490	224	5,828	889	648	495	279	30	22	15
Tucson	59,390	9,896	5,186	3,630	5,288	698	339	201	1,250	187	172	139	163	21	12	7
U.S.E.T.	93,364	15,084	9,419	6,973	5,646	459	299	151	3,225	540	404	321	383	44	30	20
TOTAL	3,003,350	450,968	293,618	214,931	208,797	19,632	11,642	6,175	106,305	15,907	12,916	10,136	14,836	1,990	1,209	820

SOURCE:
Office of Program Statistics
Indian Health Service
Health Services Administration
Department of Health, Education, and Welfare

CHART II

FY 1977

Area	Population	Number of Accidents (Care Visits)	Total Hospital Discharges - Contract & IHS	Total	Rate
Aberdeen	4,231	1,504	209	1,713	40,490
Bemidji	2,732	409	28	437	16,000
Alaska	3,831	1,119	144	1,263	32,970
Albuquerque	3,579	1,052	78	1,130	31,570
Billings	2,369	842	77	919	38,790
Navajo	7,376	2,858	214	3,072	41,650
Okla. City	17,302	1,054	122	1,176	6,800
Phoenix	5,368	1,676	273	1,949	36,300
Portland	2,773	490	22	512	18,460
Tucson	1,063	339	12	351	33,020
U.S.E.T.	1,014	299	30	329	32,450
TOTAL	51,638 (60+)	11,642	1,209	12,851	24,890

CHART III

Number of Deaths Reported For Persons Aged 60 and Over

	Information from National Safety Council	*Information from Indian Health Service*
Deaths (over 60 years)	*U.S. All Races*	*Indian*
All Accidents	28,800	114
Motor Vehicle	7,600	38
Falls	10,800	20
Burns	2,300	14
Suffocation	1,300	8
Drowning	700	6
Poisoning (solids and liquids)	500	3
Firearms	200	0
Poisoning (gases and vapors)	300	2
All other types	5,100	23

Chart I

This information was obtained from the Indian Health Service, Rockville, Maryland; the breakdown is comprehensive and much detailed. This data was used to obtain the per 100,000 population rate.

Chart II

The information on this chart is of vital importance to determine priority needs of a general safety program since it contains population figures, number of accidents reported (ambulatory patient care) plus total hospital discharges under contract care and Indian Health Service facilities. The total of these later two categories was used to compute the rate per 100,000.

Chart III

These data are being included in this report as background information and were obtained from the National Safety Council.

SUMMARY

Total accidents to the elderly represented 35.8% of all accidents occurring. Three Indian Health Service Areas constitute 51.9% of all accident incidences in the 60 and over age group. The frequency of the accidents within the above age group may account for the high accidental death rate among Indians compared with the U.S. all races information from the National Safety Council, 87.5 per 100,000 U.S. population as against 168.1 per 100,000 population for the American Indian.

Accidental Falls lead in the number of accidental injuries with 2,178; however, Motor Vehicle accidents, with a total of 348, lead in contributing to fatalities, 56 per 100,000 population, compared with U.S. total by the National Safety Council of 23.7 per 100,000 population. These are also areas of concern, because of the severity of the accidents.

A comparison of motor vehicle death rates of all ages in the U.S. shows the highest death rate is Wyoming with 66.7 per 100,000 population, followed by New Mexico with 47.0 per 100,000 population, Montana 39.8 per 100,000 population, Idaho with 33.9 per 100,000 population, and Alaska, 33.2 per 100,000 population, in that order. The Indian death rate for the 60 and over age bracket is 56 per 100,000 population.

A persistent problem accident category is "all other types" as the study reflects a death rate of 33.9 per 100,000 population as against total U.S., 1.6 per 100,000 population. The National Safety Council describes "all other types" as, most important types included are: mechanical suffocation, struck by falling object, electric current, air and rail transport and medical complications.

In the Animal-Related/Bites category, 64.6% of the accidents are occurring in Navajo, Albuquerque and Aberdeen, which indicates a need for additional information, as the "death" shown in graph M do not reflect any fatalities. Because of the large number of accidents, there is concern in reference to costs involved in hospital visits or confinement.

Accidental burns present a problem, as out of a total of 310 burn accidents, 112 occurred to the 60 years and over age bracket. The death rate is 20.6 per 100,000 population as against the National Safety Council statistics for the U.S. all races, 7.1 per 100,000 population. The Indian rate is almost four times that of the total U.S. all races.

Target Location: Unless existing program material available for each "location" (outside home, inside home, highway or street and farm) is satisfactory, more specific data must be made available before recommendations on specific program direction can be made.

Based on the absence of specific data, existing program materials were reviewed for **subjective** content and suitability for use in a **generalized** safety program for the Indian aging and aged. This program can be a first line attack to 1) increase awareness of the accident problem of the aging and aged Indian people, 2) initiate a safety program to reduce accidents among the aging Indian people, and 3) encourage the generation of necesary data to provide a secondary attack on specific accident problem areas.

RECOMMENDATIONS

Major

1. Emphasis on safety for the elderly should be placed within the existing Community Health Representative and Safety Officer programs.
2. Housing Authorities should assure that safety factors are incorporated into new housing for the elderly and handicapped.
3. Tribal leaders should be instructed as to desired safety features for all elderly-related construction of buildings on the reservations, pueblos, communities and villages.
4. Navajo, Aberdeen and Phoenix should be considered for implementing pilot projects on safety for the elderly.
5. Accident categories should be defined. In the category of "falls" there is no data known to be available to indicate what **kind** of falls (one level to another, single level falls, etc.). Fall safety programs currently available should suffice until more data can be obtained to more accurately define program direction—where accidents are occurring (inside home—kitchen, bathroom, stairs, hallway, etc.; outside home—steps, yard, walkway, off roof, off ladder, etc.); and contributing factors (eyesight, design inadequacies, lighting, housekeeping, furniture placement, rugs, floor surfaces, bathtub or shower surfaces, etc.). A greater problem of program design emerges from the "motor vehicle" accident statistics. In order to have any adequate program direction, information is required before any program is implemented unless, of course, the successfulness of the program can be left entirely to chance. Essential data needed are: what percentage of the patients were drivers, passengers, and pedestrians; and what were the causative and contributing factors of the accidents. Without this data, program effectiveness is impossible to even speculate on.

   To create a program to effectively reduce the "environmental" accidents, "Environmental Factors" must be defined. After definition, a problem profile must be established and target priorities identified. The contractor has no data to base any recommendations on. Without needed definitions and data, no reasonable attempt at program development can be made.

   General information available on prevention of cutting and piercing accident prevention should suffice until sufficient data can be gathered to dictate program development.

   "Animal Related" accidents present at least as magnificent a problem as "Environmental Factors." The contractor has no data to even indicate a program, much less a direction for it. Data required is: 1) What kind of animals are involved, 2) What circumstances surrounded the accident (pets—victim's or belonging to someone else, livestock, wild or unowned domesticated animals), 3) What kind of injuries, connection between livestock and "Falls," and 4) If bites were a problem, why were victims bitten. Data must be available before this problem can be addressed.
6. Accident categories should also reflect the number of alcohol-related incidences.

General

1. IHS and BIA should endeavor to ensure that programs for the aged are made available and presented to all reservations. This could be done through qualified agencies within or outside the federal government so that all elderly persons and tribal leaders are given the opportunity to attend.
2. Assist tribal leaders to select training officers to receive instructor training on various sites.
3. Programs should be presented in priority needs or indicated in the major recommendations.
4. A concerted effort should be made to assign responsibilities to someone for an elderly program and require training sessions for him or her.
5. Assist tribes with resource information in reference to programs and materials.
6. Design system for documenting which tribes have received instruction so impact of programs can be measured and compared with those tribes that have not received instructions.

ADDRESSES

National Safety Council
444 North Michigan
Chicago, IL 60611

National Council on the Aging
1828 L Street, N.W.
Washington, DC 20036

National Council of Senior Citizens
1511 K Street, N.W.
Washington, DC 20005

American Health Care Association
(formerly American Nursing Home Association)
1200 15th Street, N.W.
Washington, DC 20049

American Red Cross
17th and D Streets, N.W.
Washington, DC 20006

National Fire Protection Commission
470 Atlantic Avenue
Boston, MA 02210

Administration on Aging
Dept. of Health, Education and Welfare
300 Independence Avenue, S.W.
Washington, DC 20201

U.S. Consumer Product Safety Commission
5401 Westbard Avenue
Bethesda, MD 20207